Alberta Health Services

ALBERTA HEALTH SERVICES

Annual Report

2014-15

For more information about our programs and services, please visit
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or call HEALTHLink at 811.

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DR. CARL AMRHEIN
Official Administrator

LETTER OF ACCOUNTABILITY

I am pleased to present the Annual Report for Alberta Health Services (AHS) for the fiscal year ended March 31, 2015.

The 12 months summarized in this report represent progress toward becoming the health system we want to be — and a health system that Albertans deserve.

The arrival of President and CEO Vickie Kaminski in May 2014 brought new energy and renewed focus for the organization.

Ms. Kaminski and her executive team identified several key strategies designed to transform the health system, making AHS more sustainable and more responsive to patients, clients and families.

The Patient First Strategy puts patients and their families at the centre of their health care teams, and the People Strategy helps us build collaborative, interdisciplinary health care teams on which members perform to their full scope of practice. We still have a lot of work ahead to embed these strategies throughout the organization but I'm pleased important foundational work was completed on both strategies in 2014-15.

During this year, AHS addressed the financial sustainability of the organization, which became even more critical as revenues to the province fell. AHS started the process to identify efficiencies in our operations with a view that actions will not impact the level or quality of care received. At AHS, we are focused on getting maximum value out of every health dollar.

I am pleased to say that under the leadership of Ms. Kaminski, staff and physicians are participating and contributing their ideas, knowledge and expertise as the work continues.

I would also like to thank the dedicated staff, physicians and volunteers of AHS, who continue to provide and support safe, high-quality patient care each and every day. The accomplishments highlighted in this annual report couldn't be possible without them.

This Annual Report was prepared under my direction, in accordance with the *Fiscal Management Act*, *Regional Health Authorities Act* and instructions as provided by Alberta Health. All material economic and fiscal implications known as of June 4, 2015, have been considered in preparing this Annual Report.

Respectfully submitted on behalf of the Official Administrator of AHS.

[Original Signed by]

Dr. Carl Amrhein
Official Administrator

VICKIE KAMINSKI
AHS President and CEO

MESSAGE FROM AHS PRESIDENT AND CEO

This annual report covers the 2014-15 fiscal year, a time when we focused our efforts and resources toward achieving AHS' three strategic directions: bringing appropriate care to the community, partnering for better health outcomes, and achieving health system sustainability. We made significant progress over the past 12 months, and many of our achievements are profiled in this document.

Among these stories, you'll see how:

- Residents in the Sherwood Park area are benefitting from the new Strathcona Community Hospital, which offers improved access to community-based services, ambulatory care clinics and a 24-hour emergency department (ED).
- Seniors and adults with disabilities have been able to move out of hospital beds and into more appropriate community care settings with the addition of 881 new continuing care beds.
- More Albertans at the end-of-life are able to die at home as a result of a new AHS program that enables community clinicians and EMS to work together to support palliative patients where they live.
- Research and innovation are improving care and quality of life for Albertans with health issues related to stroke, cancer, mental health and addiction, kidney disease, heart disease, and osteoporosis.

AHS is there for Albertans when they need us, but we're also working to keep Albertans healthy and out of hospital. In 2014-15, we provided more influenza immunizations than ever (1.25 million), expanded screening for colorectal cancer with the easy-to-use FIT test and offered tobacco-cessation and chronic disease management workshops in communities across the province.

Yet when Albertans need the health system, we want them to be satisfied with their services. That's why we are continuing to embed throughout the organization the principles of patient- and family-centred care, which puts patients, clients and families at the centre of everything we do. And that's why we are continuing to build interdisciplinary collaborative care teams that can provide patients, clients and families a comprehensive and seamless health care experience.

We are on the right track as I'm encouraged by the fact the number of Albertans satisfied with health care services continues to rise. According to the Health Quality Council of Alberta, sixty-six per cent of Albertans were satisfied with the health care services they received, improving from sixty-four per cent in 2012.

Still, much work awaits us, and we will continue to focus on our priorities and take further steps toward becoming the sustainable, patient-and family-focused health care system we strive to be.

[Original Signed by]

Vickie Kaminski
President and Chief Executive Officer

OUR STORIES

The stories on the following pages provide a sample of accomplishments we have celebrated this past year and initiatives that are making a difference in the way health care is being delivered. The provincial highlights demonstrate how AHS is working together as one organization to deliver high-quality health care across this province.

AHS is organized into five geographic zones — South, Calgary, Central, Edmonton and North — so communities are more directly connected to their local health services and decisions can be made closer to where care is provided. In this report, we have shared some of the stories of the fantastic work that is happening in each of these zones – health care that is close to home and making a difference in the lives of Albertans.

The stories are organized according to the priorities identified in the 2014-17 Health Plan and Business Plan. Additional accomplishments and achievements follow each main story.

Enhance Primary Care

Primary health care is the first point of contact a person has with the health system. It is often provided in the community, close to home. AHS is working to ensure all Albertans have access to a primary care team and a range of health care and social service providers, no matter where they live.

Better Access to Emergency Medical Services

Emergency Medical Services (EMS) is a critical part of the health care system and an important component of the public safety net. Alberta Health and AHS continue to work together to improve the efficiency and responsiveness of EMS services.

Support Wellness and Health

Helping people stay healthy by managing their own health is an essential component of a comprehensive health system. We must work with our partners to support individuals in taking personal responsibility for their health.

Provide Continuing Care Living Options

Alberta needs more living options within our continuing care system to meet the complex and changing needs of our province's aging population. AHS is striving to provide patients and families with care where they want it most: in their homes and in their communities.

We recognize that everyone – staff, physicians and volunteers at AHS, regardless of their role, are critical in achieving this goal.

OUR STORIES

Improve Quality

Quality improvement through the application of best practices and standards continues to be a critical focus. Staff, physicians, volunteers and patients/families are key partners in health and their voices will help us build a system that makes best use of their talents and improves the quality, outcomes and value of our health system.

Incorporate Research and Innovation into Decision-Making

Strategic Clinical Networks (SCNs) are key drivers for improving patient outcomes and satisfaction, and how we deliver health care. SCNs will continue to use research and innovation in their daily work to improve the quality, outcomes and sustainability of services.

Strengthen our Provincial System

As the provincial health authority responsible for delivering services across the province, we continue to realize the benefits of a single health system. Decisions are informed by research, our experience, provincial standards and guidelines and by our information and monitoring systems that demonstrate how we are doing.

Key Enablers to Support Delivery of Services

The successful implementation of health system and service changes requires a wide variety of supports or enablers. Enablers include how we are organized; how we use our resources and engage our staff, physicians, patients and communities; how we support provincial and local initiatives; and how we apply research, technology and design information systems to improve care.

Advancing Discovery

AHS supports research and uses research-informed evidence, best practice and models to provide a road map to improved productivity and improved outcomes. Understanding health and related data is essential to monitoring, tracking and improving health system performance.

AHS accomplishments could not be achieved without our skilled and dedicated health professionals, support staff, volunteers and physicians.

ENHANCE PRIMARY HEALTH CARE

Accomplishments of actions identified in the 2014-17 Health Plan

Micheala Hiltergerke in Theatre for Living's maladjusted, *a play supported by AHS to help beat stigma around mental illness and encourage communities to create change.* Photo by: David Cooper

AHS supports community conversations on mental health

Stigma associated with mental health is a real issue. Talking openly about mental health is important.

In early 2015, AHS supported *maladjusted*, an interactive play performed across Alberta, to raise awareness of the stigma surrounding mental issues and encourage communities to be more responsive and empathetic to individuals with mental illness.

"This was more than a play. It helped create conversation at the community level on how we all can make a difference towards enhancing patient-centred care," says Dr. Laura Calhoun, Provincial Medical Director for AHS Addiction and Mental Health.

Performed by individuals with mental illness, *maladjusted* shows real stories from real people. It opens the door to conversations that focus on their care needs and offers an opportunity for vulnerable populations to have a voice into their care and their system.

Maladjusted, produced by Theatre for Living, appeared in 26 communities through B.C. and Alberta from January to March 2015. It performed across Alberta to 1,166 Albertans to help beat the stigma around mental health and illness.

For more information on *maladjusted*, visit: www.theatreforliving.com/past_work/maladjustedTour/reports_maladjusted.htm

ENHANCE PRIMARY HEALTH CARE

Under the leadership of Alberta Health, work with communities and the Primary Care Networks (PCNs) to assist in planning for additional Family Care Clinics (FCCs) across the province. The provision of extended hours and same-day access to health care teams, with services tailored to meet the needs of communities are the priorities. FCCs will continue to evolve in the province, supported by the evaluation of clinics currently in place. Work will continue to develop and evaluate service delivery options for complex high-needs populations served by FCCs. *(This action was slightly modified to reflect recent Ministerial direction on Family Care Clinics.)*

All Wave 1 Family Care Clinics (East Calgary Health Centre, East Edmonton Health Centre and Slave Lake) have implemented extended hours and same-day access to care.

Operational planning to address specific needs of complex high-needs populations is underway within the zones. Edmonton Zone has identified five initiative clusters: women and addiction initiative, home care for frail seniors, East Edmonton Boyle MacAuley, mental health younger adults under 45 years of age without chronic disease, and adults over 45 with mental health and chronic disease. The Calgary Zone successfully launched a complex, high-needs initiative at the East Calgary FCC. The South Zone has done work on patient flow, integrating it into patient quality with a focus on avoidance of hospital admissions. Five new physicians were recruited to the Slave Lake FCC in the North Zone.

Continue to support PCNs. As governance board members, AHS will continue to work with and further support PCNs. These are groups of family doctors that work with AHS and other health professionals to co-ordinate the delivery of primary health services for their patients. AHS will focus on measurement and evaluation for the PCNs, increased access to primary health care and integration of services to support continuity of care.

There are a total of 42 active PCNs in Alberta: South Zone – 2; Calgary Zone – 7; Central Zone – 12; Edmonton Zone – 9; North Zone – 12. Two new PCNs in the North Zone (High Prairie and Hinton) are in the process of establishing governance and administrative structures.

PCNs are currently developing capacity for collaborative development of common quality and outcome measures in primary care using the Measurement Capacity Initiative.

In collaboration with their PCNs, many physician offices have expanded after-hours support during key times (e.g. influenza season) to include evenings and Saturdays.

Implement priority initiatives within the Addiction and Mental Health Strategy. This includes improving how children and youth access addiction and mental health services.

An action plan to continue implementation of priorities arising from the Creating Connections: Alberta's Addiction and Mental Health Plan was created.

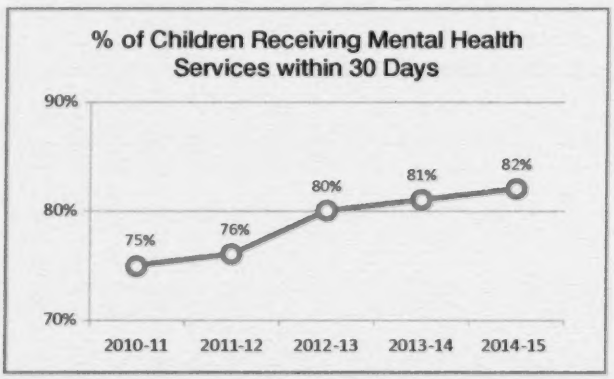
School-based addiction prevention counsellors worked in school and community settings across the zones to deliver 500 prevention activities. They reached over 10,000 school staff, students, parents and other community members.

Through the Mental Health Capacity Building Program, seniors were paired with students to participate in community-based mental health promotion activities. The Seniors Mental Health Screening Toolkit for Primary Care was completed and presented at conferences in Alberta.

AHS is contributing to the development of the Fetal Alcohol Spectrum Disorder 2015-17 five-point plan which will focus on awareness and prevention, provincial services delivery, housing and supports, criminal justice, and data capture and analysis.

AHS supported the annual Coalitions Connect. It brought together 124 delegates including representatives from 44 community coalitions, zone and provincial staff, academics and community partners. These delegates networked and learned how to build energetic and effective communities that promote moderation in alcohol use and reducing alcohol-related harm.

The North Zone developed the Aboriginal Mental Health Strategy and action plan with implementation targeted for three geographical areas. The South Zone implemented an Addiction and Mental Health Strategic Plan and an operational plan that focused on communication and information, care and service delivery, prevention, promotion and education, and workforce.



Fostering the development of healthy children, youth and families can help support good mental health.

BETTER ACCESS TO EMS

Accomplishments of actions identified in the 2014-17 Health Plan

The EMS Palliative and End-of-Life Care Assess, Treat and Refer Program brings care and dignity to palliative patients across Alberta.

EMS pushes boundaries of care

Emergency Medical Services (EMS) is bringing care to palliative and end-of-life care patients where they feel most comfortable. With the help of community clinicians, paramedics can now provide additional care in the patient's home or care facility.

Nearly 90 per cent of Albertans prefer to die outside of a hospital setting, but complex care issues have historically left community and EMS practitioners with few options but to transport patients to emergency rooms during a crisis. Under the guidance of on-call EMS physicians and palliative specialist physicians, this new province-wide program allows community clinicians and EMS to work together to treat palliative patients and keep them at home when possible.

"Patients can stay at home, in the comfort of their own bed, allowing them to die with dignity with their family at their side," says Calgary paramedic Brad Holmes.

The new program gives on-scene health care clinicians, such as home care nurses or respiratory therapists, more options to help care for patients. Now, when 911 is called for a palliative patient, the dispatcher triggers the program and sends an EMS crew without the use of lights and sirens. EMS then works with the on-scene clinician and on-call physicians to provide care that supports patient and family wishes.

Respiratory therapist James Prevost has seen the benefits of the program first-hand. "The patient ultimately died at home, which was his wish. I believe this was a direct result of care we were able to provide in the home together." By providing more care in the home, fewer palliative patients will need to go to hospital. Before the program was piloted in Edmonton, 90 per cent of palliative patients had to be taken to hospital; today, that number has dropped to just 35 per cent. That relieves pressure in emergency departments and, most important, provides a level of care that respects the wishes of patients and their families.

BETTER ACCESS TO EMS

Enhance Emergency Medical Services (EMS) by working with Alberta Health to improve efficiency and responsiveness of ground and air ambulance, consolidate EMS dispatch, develop a strategy for a new Alberta air ambulance service delivery model that includes fixed-wing and rotary-wing air ambulances, and develop an interfacility patient movement strategy.

Work continues on establishing satellite dispatch sites in Fort McMurray, Red Deer and Lethbridge. Project charters for each municipality have been completed.

A provincial plan and action plan on the Inter-Facility Transfer Service Delivery Model was completed. The plan includes an approved EMS vision and mission statements. This action fulfils a recommendation by Health Quality Council of Alberta (HQCA).

Work has begun on developing an Alberta medevac strategy and model for both fixed- and rotary-wing air ambulances. Fixed-wing ambulance contracts with service providers were successfully established.

A draft of a preliminary palliative and end-of-life care dispatch protocol was created to provide support to palliative patients who are near end-of-life.

In the Edmonton and Calgary Zones, Emergency Medical Services' community programs were developed to decrease the number of transports of patients who are identified as frequently needing service. Community paramedics are being paired with complex patients for development of effective community supports for frequent emergency department (ED) patients (Familiar Faces).

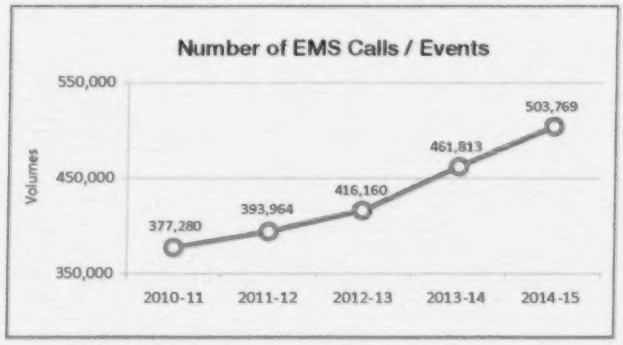
In addition, the Complex Client Team was developed to monitor and interface with EMS and ED high users in the Edmonton Zone. The team provides community medical assessment to assist specific inner-city health and community partners in obtaining non-urgent care in the community.

The Mental Health Crisis Team is currently under development. The team will partner a paramedic with a crisis worker to look for opportunities to bring care to the client in the community instead of transporting the client to care in a facility (emergency department).

In the South Zone, a Paramedic Response Unit was implemented in Medicine Hat. The paramedic works with home care to assist clients who require after-hours intravenous (IV) therapy.

In the North Zone, a pilot project plan is under development to address frequent users of EMS and the emergency department in Grande Prairie.

Training is almost complete to expand the utilization of non-ambulance transports and the initiation of critical care paramedics to the Edmonton Zone. Implementation will begin in early 2015-16.



Access to EMS is a vital component of comprehensive health care.

SUPPORT WELLNESS AND HEALTH

Accomplishments of actions identified in the 2014-17 Health Plan

Kindergarten student, Elliot, receives his routine immunizations.

Website arms parents with knowledge, kids against disease

A new website launched by AHS is encouraging parents to learn more about arming their children against disease. Immunizealberta.ca — a website developed for Alberta parents, together with Alberta parents — was launched in September 2014 and has provided more than 118,900 people with information and support as they consider immunization for their children.

As one component of AHS' efforts to increase childhood immunization rates, the website simplifies the search for credible immunization information in the crowded online environment.

"We know parents have questions and that's OK: it's healthy," says Dr. Gerry Predy, Senior Medical Officer of Health with AHS. "Parents want to keep their children safe and so do we. That's why we've taken their common questions, concerns and information requests, and put together a website that we can all trust."

Since its launch, immunizealberta.ca has remained a go-to source for questions about vaccine safety and immunity, and has also seen many visits related to emerging events.

"When we declared a pertussis outbreak in AHS Central Zone in December, the pertussis pages on immunizealberta.ca were the top pages visited for three weeks straight. Similarly, in late January and through February, when the measles outbreak in the United States was a hot topic, the site's pages about measles and getting immunized before spring travel were top ranked," says Dr. Predy.

The website has also proven valuable for public health nurses, who are on the front lines interacting with parents at routine appointments. The feedback from both parents and these health care providers continues to influence the website content.

"Front-line providers told us that the 'common questions' pages on the site were incredibly valuable and, for some questions that they hear more than others, they expressed interest in printable versions of those many questions and answers," says Dr. Predy. "We added the printable Q&A option on the site, and more feedback-driven options will continue to be added."

SUPPORT WELLNESS AND HEALTH

Partner with Alberta Health to:

Support early childhood development.

Work continues to develop an implementation action plan for the Early Childhood Hearing Screening Program, including the development of a pathway, program design and governance, and introduction of a Program Advisory Committee. This program aims to provide early identification of infants with permanent congenital hearing impairment which enables early intervention. Effective early intervention can mitigate deficits in speech and language, cognition, social and emotional and literacy/academic skills.

Bring enhancements to cancer prevention.

The volumes of Fecal Immunochemical Testing (FIT) as the primary entry-level screening test for individuals at average risk of colorectal cancer steadily increased with over 263,000 individuals aged 50-74 having completed the tests in 2014-15, a 36.2 per cent increase from 2013-14 (FIT was implemented November 2013).

A new cancer prevention campaign was launched to increase awareness. The campaign included TV, print, online and movie theatre advertising and introduced albertapreventscancer.ca: a new website that connects Albertans to an array of information, tools and resources related to cancer prevention and screening.

Three marketing strategies were launched including the Cancer Prevention Awareness Campaign (Together Campaign), HPV (Human Papillomavirus) Awareness Campaign and Decision Tool, and the Big Burn (Risks of Indoor Tanning).

Support tobacco reduction.

Tobacco Free Futures initiative expanded to addiction and mental health sites in Fort McMurray, Grande Prairie, St. Paul, Edmonton and Calgary. Videos were developed and posted online to support implementation. This initiative includes a system-wide process for identifying tobacco use in our patients, providing treatment, and arranging the appropriate documentation and follow-up for each individual. Tobacco cessation Quitkits were redesigned and distributed to clinicians across the province. A total of 25,600 Quitkits were distributed. In addition, over 51,000 prevention print resources were distributed this year.

The Tobacco and Smoke Free Environments Policy was implemented at AHS sites including the distribution of over 6,000 signage and policy resources; as well, Medicine Hat Detox and Fort McMurray treatment centres opened as tobacco-free and policy-compliant sites.

An intervention video was developed and posted on AHS YouTube site, *Reduce Vascular Risk: Assess Tobacco Use as a Vital Sign.*

Improve immunization rates.

The Immunization Web Presence Project, immunizealberta.ca, was launched in September 2014. Provincewide immunization standards were posted on the AHS website in December 2014.

A new Alberta Health vaccine distribution system for pharmacists was implemented for the 2014-15 influenza season.

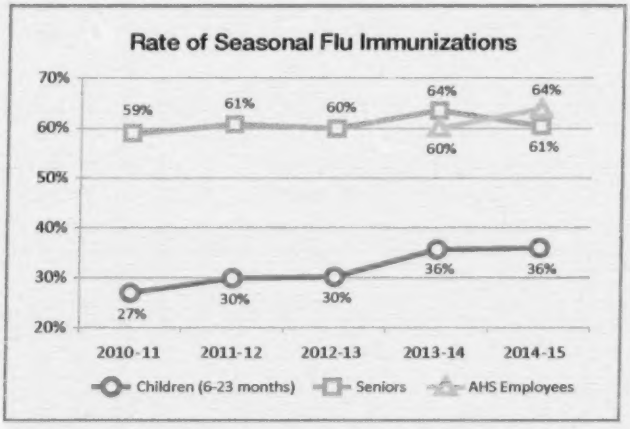
Expand health information to the public through the Personal Health Portal, myhealth.Alberta.ca.

Between 2013-14 and 2014-15, the number of visits to myhealth.Alberta.ca increased by 51 per cent to 2.4 million visits, exceeding the 50 per cent target.

A new learning module template was developed to enable improved user experience and consistency with other consumer health content on myhealth.Alberta.ca.

Patient care handouts and interactive learning modules were developed within support clinical areas to improve the consistency of health information provided to patients across the province for myhealth.Alberta.ca.

Work continues with the clinical programs to use myhealth.Alberta.ca as a platform for program content and as the single trusted source of online consumer health information. Planning continues with cancer care, and youth addictions and mental health programs to integrate with the website.



AHS continues to make progress with immunizing Albertans and ourselves.

PROVIDE CONTINUING CARE LIVING OPTIONS

Accomplishments of actions identified in the 2014-17 Health Plan

Capital Care Grandview residents Margaret Koch, left, and Phyllis Lamoureux, share a laugh and some tea with health care aide Anita Escalona.

New continuing care capacity

Late last year, AHS experienced an increase in the number of individuals waiting in hospital for a continuing care living option, putting additional pressure on emergency departments and inpatient units.

AHS worked with the province to implement a plan to fast-track more than 460 continuing care spaces across the province where the need was most critical. As of March 31, 2015, 322 beds — or 69 per cent of those promised spaces — were opened, with the remainder opening in the months ahead. In the past year, AHS has opened 881 continuing care beds.

Opening continuing care beds can have significant impacts in the community. For instance, patients waiting in hospital for a living option may be able to move to a new home that is appropriate for their care needs with a more suitable environment for day-to-day living. As beds open in a community, more hospital beds become available for those in need of inpatient acute care.

In addition to opening continuing care spaces, AHS is expanding home care services. This allows more seniors to remain safe and independent in their own homes.

Hundreds of adult day program spaces are also being added to give seniors additional opportunities for socializing, and to provide respite for caregivers.

Over a six-month period, the continuing care resolution team consulted with more than 1,000 Albertans, identifying opportunities that contribute to further improvements in Alberta's continuing care system.

Already 34 new restorative care beds have been added across the province. These beds give seniors who have been in hospital and lost strength, mobility and motor function the additional time for recovery and rehabilitation following an injury or illness, allowing them the best opportunity to return to where they lived before being hospitalized.

By adding continuing care spaces and services for seniors, AHS is improving the quality of care – and the quality of life – for Alberta seniors and their families.

PROVIDE CONTINUING CARE LIVING OPTIONS

Continue to work with Alberta Health to develop the Continuing Care Strategy. This work includes further expanding living and service options for those needing supportive living or long-term care.

Since April 1, 2014, AHS has opened 881 continuing care spaces plus 34 restorative care spaces located in acute care for a total of 915 community-based spaces. Since 2010, AHS has opened 4,284 community-based spaces. Restorative care gives clients a period of time to work on regaining their abilities, with the goal of getting back home or to the most independent level of care possible.

Focus on the quality of service delivery in continuing care, and implement improvements where required. Particular emphasis will be placed on patient and family experience.

A temporary continuing care resolution team reporting directly to AHS' Chief Executive Officer was created for patients and families with unresolved concerns related to continuing care placement or care.

A continuing care concerns phone line and email account were created as central points of intake for Albertans with unresolved continuing care concerns. It is aimed to help Albertans connect with the necessary resources and experts to provide guidance and resolution to placement or care concerns.

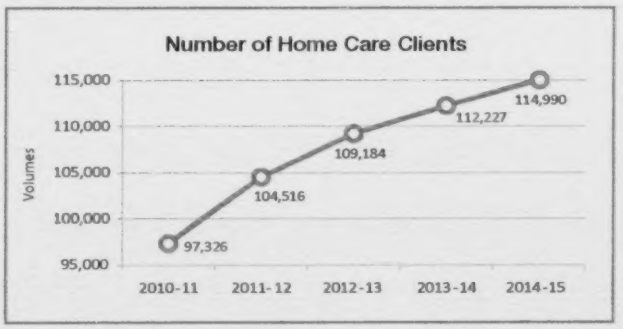
Work is underway to streamline and connect all current areas where concerns, problems, issues and incidents are registered, tracked and monitored. This will greatly improve AHS' ability to track, trend and resolve issues and concerns.

Enhance home care by expanding complex and basic adult day programs, and by additional (24/7) nurse support, respite care, geographic teams of care and self-managed care.

Work continues with Alberta Health to standardize home care services by defining core services. A national pilot project between Canadian Home Care Association and Health Canada commenced January 2015, focusing on formulating a detailed basic basket of services and supporting services hours based on current best practices across Canada.

Since its inception, 5,587 unique clients have been served through the Destination Home projects in Edmonton and Calgary. Destination Home supports seniors with complex needs to remain independent as long as safely possible.

The Self Managed Care Policy was developed and sets out eligibility requirements and a consistent process for initiating and approving self-managed care. Standard provincial education and orientation resources were developed and will be rolled out with the policy and procedure.



AHS continues to strive to provide patients and families with care where they want it most: in their homes and in their communities.

Continue to develop and begin implementation of the Palliative and End of Life Care (PEOLC) Strategy to support Albertans being cared for and dying in their place of choice.

Education materials for emergency communications officers, community clinicians and emergency medical services practitioners were produced. Training is currently underway in preparation for rollout across the province tailored by zone.

A 24/7 PEOLC palliative physician on call specialist consultation service is available for practitioners in all pediatric and adult programs within every geography across Alberta.

A central PEOLC webspace was developed and launched for all Albertans. This was created in partnership with Alberta Health. A new "Health Channels" and "Health Topics" will be displayed on myhealth.Alberta.ca and integrated in the future with the personal health portal.

IMPROVE QUALITY

Accomplishments of actions identified in the 2014-17 Health Plan

Breast cancer patient Meredith Hodges, centre, looks over her Screening for Distress questionnaire with program founder Dr. Barry Bultz and Linda Watson, Lead of Person-Centred Care Integration for AHS.

Cancer Care – Screening for Distress

Fewer Alberta cancer patients are experiencing severe distress as a result of their illness and treatment since the launch of a program developed at the Tom Baker Cancer Centre.

Screening for Distress is improving the cancer journey for patients across the province by identifying the psychosocial and practical impacts of the disease and providing solutions.

"The program is changing the approach to health care by opening up meaningful conversations between patients and front-line staff," says Linda Watson, Lead of Person-Centred Care Integration.

Distress is classified as an unpleasant emotional experience ranging from vulnerability and sadness, to disabling problems, such as anxiety and depression, and can interfere with a patient's ability to cope effectively with cancer.

Patients complete a brief questionnaire and then work with front-line staff to develop an action plan to mitigate or eliminate the cause(s) of distress. More than 1,000 patients were assessed as part of a recent evaluation of the program and the majority of patients reported a lower level of distress.

High River resident Meredith Hodges completed the program following her breast cancer diagnosis and indicated she was becoming increasingly concerned her illness was damaging her marriage.

"The screening talk allowed me to open up about the distress I was feeling," she says. "It helped me understand my own situation and brought me closer to my husband."

Screening for Distress was conceived in the late 1990s at the Tom Baker Cancer Centre by a team led by Dr. Barry Bultz, Clinical Lead of Psychosocial Oncology, Supportive Care and Patient Experience.

Today, distress is now endorsed by more than 75 international organizations and societies, including the Union for International Cancer Control, as the "sixth vital sign" in cancer care, following temperature, pulse, blood pressure, breathing rate and pain.

The Alberta Cancer Foundation provided funds to develop the program and implement it provincewide.

IMPROVE QUALITY

Develop our Patient First Strategy to enhance patient-focused care and improve patient satisfaction.

The Patient First Strategy was launched, and various initiatives are underway across the province.

Work is ongoing to improve the effectiveness of the patient concerns resolution process. A patient relations survey for patients and families was completed, and consultations were held with various stakeholders.

Patients continue to provide feedback on their meal experience using the Enhancing the Patient Meal Experience Appreciative Inquiry tool which was introduced and assessed at all sites.

Staff attended over 400 resident council and Health Advisory Councils meetings in 2014-15.

The North Zone is currently developing a patient-centred community engagement action plan for establishing patient- and family-centred care.

Enhance acute care flow through the Co-ACT initiative.

Co-ACT is an innovative model of care in which care providers collaborate more closely with patients. Co-ACT implementation is underway in all zones with positive impact on efficiency and on emergency department flow. Overall progress is on schedule at 44 per cent for 20 sites. (Target was 40 per cent.)

Examples of zone flow initiatives include: implementing care hubs, team huddles, comfort rounds, Name-Occupation-Duty (NOD), whiteboards, Rapid Round Boards, and Anticipated Date of Discharge (ADOD); piloting the Green Bar project aimed at improving the transfer process; implementing a modified Rapid Assessment Zone to address access to physician assessment time; enhancing Medworxx to identify delays in service or care; and establishing quality councils to support a quality improvement approach.

Focus on accreditation standards, such as reprocessing and sterilization of reusable medical devices, infection prevention and control (IPC), and hand hygiene. We will also implement a stewardship program to promote wise use of antimicrobials.

AHS participated in the May 2014 Accreditation Canada survey. Evidence submitted to Accreditation Canada in October 2014 addressing outstanding Required Organizational Practice (ROP) criteria (hand hygiene compliance, hand hygiene education, infection rates, reprocessing of medical devices) was accepted.

All Service Excellence Teams for clinical service standards and ROP were established in preparation for accreditation in May 2015.

The provincial ROP resource materials have been developed and implementation commenced. Medication reconciliation ROP is addressed by provincial medication reconciliation team and the zone-based medication teams.

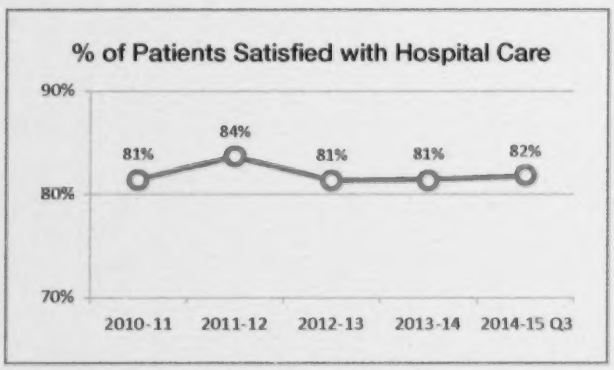
The zones continue to implement specific activities related to antimicrobial stewardship with an initial focus on *C. difficile* including treatment algorithms, standardized care orders, pre-printed medication orders and surveillance audits. An audit at six AHS sites of *C. difficile* toxin positive patients is near completion. In addition, a systematic review of clinical practice guidelines was completed.

Focus on quality improvement and ongoing performance monitoring and measurement, such as a quality management framework, comprehensive diagnostic imaging quality assurance program, environmental services cleanliness audits and continued efforts to promote a patient safety culture.

The Quality Management Framework was approved in principle. Communication, dissemination and evaluation is under development. Each year, 18,000 providers have accessed simulation with a primary focus on effective teamwork and communication skills. The Quality and Healthcare Improvement Integrated Curriculum was implemented.

Independent cleanliness audits were conducted at five urban sites. Recommendations from the report were shared with leadership for implementation in 2015-16.

A web-based environmental services quality assurance tool is currently under development to generate just-in-time reporting in response to outbreaks, address prevention of hospital acquired infections and provide benchmarks.



AHS needs to hear from Albertans to ensure we are supporting them in achieving better health, and better health outcomes.

IMPROVE QUALITY

A large focus this year was on Ebola Virus Disease preparation and practices, including reviewing and refreshing Personal Protective Equipment (PPE) protocols and developing educational material to support Ebola PPE and clinical practice requirements for the care of persons with suspect or confirmed Ebola Virus Disease.

Provincewide review of medical device reprocessing (MDR) practices is near completion in all centralized and decentralized MDR locations in AHS, Covenant Health, and AHS contracted agencies and services.

An infection prevention and control (IPC) orientation module for physicians was launched in collaboration with AHS Medical Affairs. In 2014-15, IPC online education modules were completed with over 2,300 new staff completing the corporate orientation module and over 39,400 clinical staff completing the annual continuing education module.

Improve cancer care in the province by improving patient flow in all Cancer Control sites and programs by making best use of space, people and equipment that will lead to improved access and better clinical outcomes and will contribute to a fiscally sustainable strategy for cancer treatment in Alberta. This will be supported by integrating and coordinating bone marrow transplant services in northern Alberta, establishing a patient-centred care approach to support coordination of services and enhancing performance reporting. Lung cancer surgeries and diagnostic procedures will be increased to improve rapid and coordinated access.

Operational improvement initiatives at tertiary cancer centres were initiated to optimize the use of health professionals and resources with the goal of improving patients' access to care. Examples of projects include:

- Tom Baker Cancer Centre (TBCC) is focusing on reducing Radiation Therapy "Ready-to-Treat to Treat" times for breast cancer patients by 30 per cent. The project team defined appropriate time stamps to ensure common understanding of the problem as well as the opportunity.
- Ambulatory Clinic Optimization is intended to address major capacity issues at the TBCC. The goal is to decrease patient wait time by 25 per cent, decrease registered nurse overtime by 10 to 15 per cent, and increase capacity by 10 to 15 per cent. The work requires the phased rollout of standardized business rules to 138 clinics by the end of August 2015. Phase 1 is complete and successful. Full outcomes will follow upon completion of rollout.
- Cross Cancer Institute selected Bone Marrow Transplant (BMT) to create capacity for the growing demand for BMT services. Capacity will be impacted by the addition of a third collection machine.
- AHS Improvement Way (AIW) Green Belt candidates in cancer care completed the first steps towards certification; they will take on a more significant role in implementing the second round of improvement initiatives in 2015-16.

The Alberta Thoracic Oncology Program (ATOP) monitors clinical activity to measure performance. The program expanded the diagnostic imaging notification program to the Grande Prairie Hospital in the North Zone. While the number of patients referred to the ATOP clinics continues to grow, surgical wait times have improved since new surgical resources became available in Calgary and Edmonton in September 2014.

A robust performance report was established which drives quality and accountability through a set of cancer performance measures specific to Alberta's cancer system.

Establish a patient-centred care approach to support coordination of services.

The Building Capacities: Cancer Prevention and Collaborative Initiatives to Empower Survivors in partnership with Alberta Cancer Prevention Legacy Fund and Cancer Control Alberta was implemented including the development of guidelines for breast and prostate cancers; testicular cancer is near completion.

The implementation and evaluation of Screening for Distress as routine care was completed in 17 cancer centres.

Five Communities of Practice were initiated in rural Alberta (Red Deer, Fort McMurray, High River, Drayton Valley and Barrhead) to provide effective development and coordination of community and health system-based services for the support of patients with cancer.

INCORPORATE RESEARCH AND INNOVATION INTO DECISION-MAKING

Accomplishments of actions identified in the 2014-17 Health Plan

Kristyn Zaminer is an AHS Health Link staff member who works in the new Catch a Break program which helps Albertans catch osteoporosis early and pursue treatment to strengthen bones and prevent future breaks.

New program detects osteoporosis early

Edward Kohel thought his bones were strong and healthy, even after cracking his wrist following a slip on ice. But now, thanks to the Catch a Break program, the 61-year-old St. Albert man is taking steps to find out if he has osteoporosis, a disease that causes bones to become thin and brittle.

Catch a Break identifies Albertans in the early stages of osteoporosis and connects them with resources to help prevent the disease from progressing.

"I was really impressed the follow-up was made," says Kohel of the phone call he received. "When it comes down to patient care, this program is great."

Catch a Break was developed by the AHS Bone and Joint Health Strategic Clinical Network, in conjunction with the Alberta Bone and Joint Health Institute.

Every year, almost 2,400 Albertans who fracture a hip have osteoporosis but most are unaware. Catch a Break is about making sure a patient's first fragility fracture is their last.

More than 5,000 Albertans have been contacted since the program launched in June 2014. Nearly 80 per cent of those have been identified as being at high risk for osteoporosis and 73 per cent have visited their doctor as a result.

Catch a Break is operated by AHS staff through Health Link which uses data from emergency departments and cast clinics to identify participants. When connecting with patients, staff ask for information about how the fracture occurred; if a fragility fracture is suspected, the patient is invited to join the Catch a Break program.

Participants are mailed information, including risk factors and how to use calcium, vitamin D and exercise to strengthen bones. Information is also sent to their family doctor.

INCORPORATE RESEARCH AND INNOVATION INTO DECISION-MAKING

Strategic Clinical Networks – Driving Innovation To Improve Health Care

Strategic Clinical Networks (SCNs) are creating improvements within focused areas of health care.

To get the most out of our health care system, AHS has developed networks of people who are passionate and knowledgeable about specific areas of health, challenging them to find new and innovative ways of delivering care that will provide better quality, better outcomes and better value for every Albertan.

By the end of 2014-15, there were 11 SCNs, comprised of patients and families, physicians, clinicians, community partners, researchers and staff:

- Addiction and Mental Health
- Bone and Joint Health
- Cancer
- Cardiovascular Health and Stroke
- Critical Care
- Emergency
- Obesity, Diabetes and Nutrition
- Respiratory
- Seniors' Health
- Surgery
- Maternal Newborn Child & Youth

Alberta's 11th SCN took its first steps in mid-March. The Maternal Newborn Child & Youth (MNCY) SCN brings together 35 experts on its core committee, with a goal to improve and coordinate care across these four inter-connected areas of health. The committee includes physicians, front-line clinical staff, administrators, researchers, and patients and families from AHS and stakeholder organizations.

Over the last year, the SCNs have continued working on improving the health care system and are currently focused on nine projects:

The following page lists SCN key accomplishments for actions identified in the 2014-17 Health Plan.

Stroke survivor and Red Deer resident, Elwood Kirkpatrick performs a motor skills test while therapy assistant Jolene Boutin observes. Stroke patients, like Elwood who live in small urban and rural settings, can expect the same level of care delivered in larger centres thanks to the Stroke Action Plan, a project of the Cardiovascular Health and Stroke Strategic Clinic Network. Stroke Action Plan has achieved national recognition, and was awarded the Co-Chair's Award for Impact by the 2014 Canadian Stroke Congress.

INCORPORATE RESEARCH AND INNOVATION INTO DECISION-MAKING

Develop treatment approaches for adult depression.

A randomized clinical trial was conducted within primary care to assess the effectiveness of different interventions for depression treatment. Surveys were conducted with patients, family physicians, and clinicians, representing 21 Primary Care Networks across Alberta.

Reduce wait times, improve access to operating rooms, improve outcomes of patients who experience hip fracture, and prevent secondary hip fractures.

eReferral, which improves coordination for streamlining referrals and reducing wait times was launched in 10 hip and knee arthroplasty locations. eReferral is one of three recipients of a LEADing practice award from Accreditation Canadian and Canada Health Infoway.

A post acute-restorative care hip fracture pathway was developed including tools and resources for patients, families and providers.

Reduce the use of antipsychotic medications to improve outcomes of long-term care residents.

The Appropriate Use of Antipsychotics (AUA) Guideline and Toolkit were developed with extensive engagement from staff and physicians. The toolkit is posted on the external AHS webpage and has received favourable evaluation from staff. Early adopter units continue to sustain and improve their efforts to reduce antipsychotic use. This work has spread to all units in 10 sites. Ninety-five per cent of long-term care sites are engaged with the AUA project by attending either an information session or by participating in a series of learning workshops.

Continue the implementation of the Safe Surgery Checklist.

The Safe Surgery Checklist project is complete and has successfully transitioned to clinical operations as of December 2014. The use of the checklist resulted in "good catches" for four per cent of surgical cases in Alberta. Compliance of the checklist has been consistently above 92 per cent provincially.

Identify and support people at risk for heart disease and stroke.

Risk factor screening and management was established in 40 pharmacies where 615 patients were enrolled. Approximately 390 primary care providers are actively participating, representing 350,000 adult Albertans. This includes 205 rural, 129 metro and 56 academic providers.

Integrated approaches to vascular risk reduction were implemented in Medicine Hat; as well as at the Slave Lake Family Care Clinic. A shared care plan is currently being piloted in Calgary with Mosaic Primary Care Network and in Edmonton with a Stroke Prevention Clinic.

Improve access via electronic referral initially for lung and breast cancer surgery and joint replacement surgery.

eReferral was successfully launched in cancer centres across the province for breast and lung cancer in July 2014. As of March 2015, 699 breast cancer referrals, 128 lung cancer referrals and 293 hip and knee referrals were sent via eReferral.

Implement new and consistent ways of managing care before, during and after specific colorectal surgeries by focus on mobility, nutrition, hydration and pain management.

Enhanced Recovery after Surgery (ERAS) implemented colorectal protocols at six acute care sites across Alberta. Compliance with the protocol has increased at all sites from 40 per cent to 63 per cent. Sites achieved target to decrease length of stay to six days which is a reduction of two days. Sites achieved targets to reduce complication/ readmission rates by 20 per cent compared to 56.5 per cent in 2012-13.

Standardize surgical wait times based on patient's condition and level of urgency.

Adult Coding Access Targets for Surgery (aCATS) were implemented for 70 per cent of adult surgeries in Alberta. Target was 78 per cent. Spread completed at Red Deer, Wetaskiwin, Vermillion, Olds, Innisfail, Lamont, Viking and Daysland. Fourteen sites are in the sustain phase.

Improve quality and availability of stroke care in rural Alberta.

The Early Supported Discharge (ESD) and Stroke Unit Equivalent Care (SUEC) projects were awarded the 2014 Canadian Stroke Congress Chairs' Award for Impact.

By March 2015, 574 ESD patients were enrolled at five participating sites and 2,448 SUEC patients received care at 14 participating sites.

STRENGTHEN OUR PROVINCIAL SYSTEM

Accomplishments of actions identified in the 2014-17 Health Plan

A room at Red Deer Regional Hospital Centre has been renovated into a space for the peritoneal dialysis training program. AHS staff members Alanna Colosimo (RN), Andrea Luca (RN), Dr. Kim Jym, and Kristal Larsen (RN) are part of the team which trains patients to use home peritoneal dialysis.

Home dialysis training comes to Red Deer

More central Albertans are able to access home peritoneal dialysis thanks to a new training program launched at the Red Deer Regional Hospital Centre in October 2014.

"It provides patients the opportunity to do dialysis in their own home instead of the hospital," explains Tracy Schwartz, Patient Care Manager for the Northern Alberta Renal Program (NARP).

Prior to the launch of the local training program, patients needed to travel to Edmonton to receive home peritoneal dialysis training. Since October 2014, 17 more people have been trained in Red Deer.

"It allows us to put people on home peritoneal dialysis who otherwise couldn't have travelled to Edmonton to get the training," says Dr. Kym Jim.

Irene Zimmer of Red Deer took the training after spending six months receiving hemodialysis three times a week at Red Deer Regional Hospital Centre.

"With home dialysis, you get your life back," says Zimmer, who is now able to utilize peritoneal dialysis equipment in the comfort of her home while she sleeps.

This year, NARP and the Southern Alberta Renal Program began functioning as one renal program, Alberta Kidney Care. This unity strengthens shared knowledge while Alberta Kidney Care continues to work on solutions to address growth.

Going forward, Alberta Kidney Care will focus on offering patients requiring dialysis more home dialysis treatment options. This will improve quality of life and clinical outcomes, while reducing costs.

Further renovations at Red Deer Regional Hospital Centre are expected in the Fall to create new access to home hemodialysis training. Expansion of the home dialysis training program is supported by the Red Deer Regional Health Foundation.

STRENGTHEN OUR PROVINCIAL SYSTEM

Continue our commitment to deliver specialized provincial services to patients requiring complex interventions such as cardiovascular surgery and renal services.

Cardiovascular surgery capacity increased by completing an additional 139 cardiac surgeries in the Calgary Zone and an additional 228 cardiac surgeries in the Edmonton Zone. One additional cardiovascular intensive care bed opened in the Calgary Zone, and three cardiovascular intensive care beds and four cardiac surgery ward beds opened in the Edmonton Zone to accommodate increased surgical activity. An additional 139 cardiac surgeries were completed in the Calgary Zone, an additional 228 cardiac surgeries in the Edmonton Zone.

An Alberta Kidney Care Plan was developed. A monthly screening, treatment and monitoring kidney care clinic was established at the Lavern Clinic in the South Zone and is now well established in the Blood Tribe. A third hemodialysis run was added at the Sheldon M. Chumir Health Centre in Calgary in May 2014. There are approximately 24 dialysis spots remaining in Calgary. Recruitment and training to support additional dialysis runs were completed.

Develop service plans to address capacity issues and align services to population health and community needs.

The Calgary Zone is finalizing plans for redistribution of obstetrical activity. The Obstetrical Capacity Protocol was implemented in the Calgary Zone. Other initiatives include pre-registering pregnant women at the facility where they will give birth and the creation of a monthly report to monitor activity across the urban site. In April 2014, five new antepartum beds at Foothills Medical Centre opened temporarily while redistribution work continues.

AHS participated in the Western Canadian Collaborative for Donation and Transplantation meeting held May 2014 in Winnipeg, Manitoba. The AHS Organ Transplantation Program Review proposal was completed. Preparation for 2015 Accreditation continues. A Service Excellence Team is in place, and working groups were established to prepare and implement the detailed plans.

Development of the long-range plan for the Central Zone has commenced with progress made in recruiting a project team, determining scope to include acute and community services, gathering of data and establishing stakeholder groups. Mental health, surgery and obstetric plans will be incorporated.

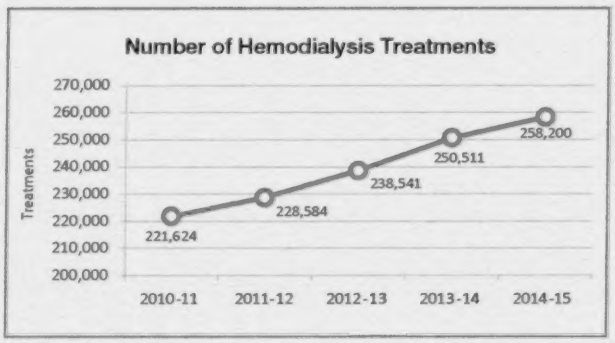
The Edmonton Zone 2030 plan is complete. It includes mapping existing health facilities using an online tool showing age, expected life cycle, size and use of each facility is complete. Site profiles were completed for 15 sites. Master plans for Royal Alexandra Hospital and Misericordia Community Hospital are currently underway.

Integrate the laboratory services delivery model that is responsive and improves quality and patient safety.

AHS has selected a preferred vendor via a formal request for proposal process in October 2014 for an integrated laboratory service provider.

Continue to enhance our preparedness for emergency disaster management.

The South Zone is working on a site-based, comprehensive Code Orange (mass casualty incident) emergency response plan. The plans include identification of Physical Site Command Post locations, a department-based fan-out process; a disaster supply cart with a rotating stock system to ensure supply expiries are managed; and red, yellow, green treatment areas and identification of locations for a family support centre and a staff redeployment/demobilization centre.



A new home dialysis training program was initiated to provide more Albertans the ability to access home dialysis.

KEY ENABLERS TO SUPPORT DELIVERY OF SERVICES

Accomplishments of actions identified in the 2014-17 Health Plan

Strathcona Community Hospital is an innovative facility, delivering primary health care, combined with community-based services and a 24-hour emergency department supported by on-site diagnostic and laboratory services.

Strathcona Community Hospital celebrates one year

The Strathcona Community Hospital features a 24-hour emergency department, diagnostic imaging services (including ultrasound and computerized tomography [CT] scanner), community laboratory services, children, youth and families, addiction and mental health, community rehabilitation services, chronic disease management patient education and outpatient clinics. The site is supported by a foundation comprised of members from the local business and area community.

Approximately 80 per cent of patients utilizing the facility are from Sherwood Park and Strathcona County, with the remainder from Edmonton and other nearby communities.

In Sherwood Park, since opening in May 2014, the Strathcona Community Hospital has exceeded patient visit projections, requiring additional physician shifts in the emergency department. The $130-million facility, the newest hospital in the province, received over 25,000 emergency department visits from May to December 2014, relieving some pressure on nearby facilities. The hospital staff and physicians are equipped to deal with all types of emergency, urgent and complicated cases. The onsite Emergency Medical Services team can rapidly transport the three to four per cent of patients requiring advanced care and diagnostics to a site providing specialized care in the region.

Although volumes are higher than anticipated, the emergency department wait times are among the shortest waiting times of hospitals around the region. This new facility brings a number of services to the community that have not previously been available, most notably, a 24-hour emergency department and CT scanning.

The Strathcona Community Hospital has been constructed with recent innovations that support energy efficiency in heat and water conservation, infection prevention and patient/family support. There is also room for future expansion on the site. The new hospital, in partnership with other community providers, is committed to providing patient- and family-centred care.

KEY ENABLERS TO SUPPORT DELIVERY OF SERVICES

Continue to develop the health care workforce to support the delivery of the appropriate service by the appropriate provider in the appropriate place.

TeamCARE involves a team-based training program that seeks to improve the reliability of care and enhance patient safety through empowering staff with teamwork, communication skills and techniques. An example of its application was its effectiveness in reducing depressive symptoms in patients with Type 2 diabetes through a nurse-led collaborative care model implemented in four Primary Care Networks.

A workforce plan for Staff Scheduling Transformation was developed to guide several workforce initiatives. Staffing service centres opened in Edmonton Zone and planning is ongoing for two new service centres for the Calgary and North Zones.

The implementation of rotation optimization continues within clinical and non-clinical areas. The goal is to find the right balance of full- and part-time positions so patients see the same faces and build better relationships with their care providers.

Continue efforts to reduce occupational injury in AHS' workplaces.

Work continues to ensure a safe physical environment; support workers to improve their personal health and resiliency to cope with work and life demands; improve the psychological safety aspects of the work environment; establish a management system to support health, safety and wellness, including strengthening safety accountability from leadership to the front lines; and build on behaviours and cultural attributes that will establish a strong safety culture.

Develop and implement an organization-wide People Strategy that includes a focus on employee and physician engagement and annual employee and physician engagement surveys.

Work continues on finalizing the People Strategy which outlines how AHS supports its people to deliver patient- and family-centred care. Consultation with staff, managers, volunteers, corporate partners, unions and regulatory bodies were conducted. An implementation plan will be developed following final approval of the People Strategy in September 2015.

Develop a five-year strategy to optimize the implementation of new information technology and information management to support the delivery of care on the front lines.

An Information Management and Information Technology Strategic Plan was submitted to Alberta Health for review in March 2015. The plan includes a clinical information system roadmap and infrastructure plans.

Continue to develop and enhance clinical information systems in ambulatory and acute care settings across the province to leverage the value proposition of a provincially integrated health system.

The Alberta Netcare Portal is a repository that contains the health information of all Albertans. An access process has been refined to meet regulatory and other requirements. To date, there are over 28,000 Netcare users (compared to approximately 11,800 in 2010-11).

eCLINICIAN implementation continues in ambulatory and outpatients clinics. It provides a shared electronic medical record and access to scheduling systems for Edmonton Zone ambulatory outpatient services.

Significant work on optimization, stabilization and upgrading of Meditech was undertaken in support of clinical information systems in the South, Central and North Zones.

Ensure we are using the data we collect and analyze effectively to support informed clinical, operational and strategic decisions.

The Priority Performance Measure Transition is complete – with 17 strategic performance measures defined.

The Provincial Health Analytics Network Analytic Question Prioritization Model and Information Products Access are complete.

Continue to support the implementation of major capital projects in 2014-15.

The new Strathcona Community Hospital opened in Sherwood Park in May 2014.

ADVANCING DISCOVERY

Accomplishments of actions identified in the 2014-17 Health Plan

University of Calgary researcher Dr. Michael Hill with stroke patient Basma Khouloussi.

New procedure revolutionizes treatment for stroke

Basma Khouloussi remembers little of her stroke last August.

"My husband noticed I wasn't speaking very well and the right side of my body completely stopped working," says the 41-year-old Calgary woman. "If it hadn't been for the care I received at Foothills Hospital, who knows where I would be today."

Thanks to a revolutionary new procedure to treat patients who have suffered a stroke, Khouloussi sustained no long-term side-effects.

Endovascular treatment (ET) is a clot retrieval procedure that has been shown to dramatically improve outcomes for patients after an acute ischemic stroke and reduce the likelihood of death.

In an international randomized trial led by three AHS researchers based in Calgary, ET reduced mortality rates by 50 per cent – from two in 10 patients to one in 10 patients.

The procedure also increased positive outcomes from 30 per cent to 55 per cent. In many cases, rather than sustaining major neurological disability, patients went home to resume their normal lives.

The study included 22 sites worldwide, including Foothills Medical Centre and University of Alberta Hospital. Results of the international randomized study were published in the February 11 online edition of the *New England Journal of Medicine*.

"This is the most significant and fundamental change in acute ischemic stroke treatment in the last 20 years. These results will impact stroke care around the world," says Dr. Michael Hill, AHS neurologist with the Calgary Stroke Program and senior author of the study.

ADVANCING DISCOVERY

Work with Alberta Health and other partners to further develop and implement strategies that focus on: increasing the province's capacity to use health and related data to inform research and develop services.

AHS and Alberta Health continued to develop the Provincial Health Analytics Network (PHAN), which enables relevant and timely access to high-quality health information for those organizations in Alberta that need health data to deliver on their mandates, including health researchers. AHS has completed the groundwork for integrating the Discharge Abstract Database (DAD) and National Ambulatory Care Reporting System (NACRS) data assets into the PHAN. These data assets represent both inpatient and outpatient data and are used extensively by health system stakeholders within AHS, the Ministry and external researchers. As well, AHS has embedded analysts within Alberta's universities to increase their access to AHS data assets to support health research.

Work with Alberta Health and other partners to further develop and implement strategies that focus on supporting health research and innovation through the Alberta Partnership for Research and Innovation in Health System (PRIHS) grants, and developing a research action plan to spread and implement innovations.

A strategy for Research, Innovation and Analytics has been developed and is currently under review. Five strategic directions were identified. Engagement was completed with key stakeholders, such as patients, senior leadership and representatives from universities.

Ten new PRIHS projects were awarded funding in December 2014, for a total of 20 now underway.

Examples of research successes in 2014-15:

- A collaborative research project between AHS and the University of Alberta's Faculty of Rehabilitation Medicine is using GPS technology to locate Albertans with cognitive impairment who have wandered or are lost. The Locator Device Project is underway in Calgary and Grande Prairie and examines how GPS technology within a wrist watch, a shoe, and a small cellphone-like device may help improve the safety and quality of life for these Albertans and their caregivers.

- Youth with heart disease are gaining knowledge and self-management skills to transition to a healthier lifetime of follow-up care as adults thanks to clinical research at the Stollery Children's Hospital. The findings of the Congenital Heart Adolescents Participating in Transition Evaluation Research (CHAPTER) study show that educational sessions make a positive difference for youth with congenital or acquired heart disease. The sessions taught teens about heart anatomy, reviewed previous operations and procedures, and showed them how to obtain adult cardiology care.

- A new clinical care pathway is helping patients who have had a tracheotomy to start recovery from the procedure in less than half the time it once took. In a tracheotomy, a surgeon inserts a tube in a patient's trachea to assist with breathing. The sooner the tube is removed, the less likely the patient will develop an infection or the trachea will collapse after the tube is removed. The guidelines, which only apply to patients considered at low-risk of any other medical complications, are now being used across the Calgary Zone. Clinicians are currently developing a post-tracheotomy guideline for more complex, high-risk cases. The next step will be to formalize the guidelines in a policy format and then introduce them provincewide.

- An experimental treatment called deep brain stimulation (DBS) shows promising results for depression in a research study at AHS' Foothills Medical Centre. The therapy involves surgically implanting electrodes to deliver impulses to the brain. Early research indicates about one-in-two people undergoing DBS will experience at least a 50 per cent decrease in the severity of depression. Within that group, depression will almost disappear in half of those people. DBS is for those individuals who have tried most standard therapies, including anti-depressants and counselling, but are still unable to work or have much of a social life.

- A new research study underway in the emergency department at Foothills Medical Centre shows promise for speeding up the diagnosis of patients who arrive with heart attack symptoms. Researchers are evaluating the reliability of a new blood-screening procedure (troponin) that shortens by several hours the time it takes for physicians to rule out a heart attack. If the test proves accurate, not only would it improve care for cardiac patients, it will also improve flow in congested emergency departments.

- A study, led by researchers at the Mazankowski Alberta Heart Institute, the CK Hui Heart Centre and the Faculty of Medicine & Dentistry at the University of Alberta, highlights the life-saving benefits of the Vital Heart Response system. By injecting a clot-buster to abort a heart attack before it happens, ideally during a patient's ambulance ride to hospital, heart muscle damage can be prevented. This is yet another example of how made-in-Alberta innovations are saving the lives of Albertans and making the province a global leader in the area of cardiac care.

2014-15 | SOUTH ZONE HIGHLIGHTS

Internal medical specialist Dr. Aaron Low with patient Harold Brown, 65. Brown was one of 15 patients in southern Alberta living with life-threatening irregular heart rhythms until Dr. Low installed a new implantable cardioverter-defibrillator (ICD) available at Chinook Regional Hospital.

Chinook Regional offers new service for cardiac patients

Almost three years ago, Lethbridge resident Harold Brown, 65, suffered a major attack that could have cost him his life had it not been for a new implantable defibrillator (ICD) that can jump-start a failing heart.

"I actually flatlined," says Brown. "I would have needed to go to Calgary for testing to see about getting a defibrillator, but then I found out the testing and surgery could be done here."

Chinook Regional Hospital is the fourth acute care site in the province that can implant the life-saving devices. Brown is one of 15 patients at Chinook Regional Hospital who received an ICD—a small battery-powered generator that constantly monitors the heart's performance and corrects its rhythm by delivering a brief electrical impulse. The device is used to control life-threatening irregular heart rhythms, especially those that can cause sudden cardiac arrest.

"Similar to when Emergency Medical Services shocks a patient in cardiac arrest with a defibrillator, these devices do the same thing, except they're implanted in the chest and the leads contact to the heart directly," says internal medicine specialist Dr. Aaron Low, who performs the procedure at Chinook Regional Hospital. He says research has shown the ICDs reduce mortality rates in patients with impaired heart function.

Previously, southern Albertans who needed an ICD would have the procedure done in Calgary at the Foothills Medical Centre, or in Edmonton at either the University of Alberta Hospital or Royal Alexandra Hospital.

"Some patients will still need to go to Calgary or Edmonton if they require more advanced testing," says Dr. Low. "But having this resource available here is a real bonus for some local cardiac patients, and it takes some of the wait-time pressures off those other facilities."

Brown's two-hour procedure was performed in Chinook's newly renovated day procedures unit. Two hours later, Brown was already back on his feet and able to return home the following day.

"Being able to have it all done close to home is great," says Brown. Alberta physicians implant about 800 ICDs annually.

SOUTH ZONE HIGHLIGHTS

New contract with Lethbridge Fire and Emergency Medical Services (EMS) adds resources:

Ambulance and emergency response capacity in Lethbridge was enhanced in September 2014 to meet demand during peak hours under a new multi-year contract between the City of Lethbridge and AHS. The contract provides a core service of four ground ambulances around the clock, ramping up to a total of eight ambulances each day during peak-demand hours between noon and 7 p.m.

Patients enjoy convenience of new catheter technology:

In May 2014, a new way of doing intravenous therapy is saving time and eliminating the need for X-rays for patients at Chinook Regional Hospital. Patients prescribed long-term chemotherapy, extended courses of intravenous antibiotics or other medications or blood products often require the insertion of a peripherally inserted central catheter (PICC line) to administer drugs directly into their circulatory system. A team of highly-skilled registered nurses is the first in the province to use a new system that relies on ECG (electrocardiogram) technology and magnetic tracking to confirm positioning of the line. The new method takes less than an hour. Once in place, the line remains as a portal for medication for weeks, months or even years.

Medicine Hat EMS adds resources:

In February 2015, AHS added EMS vehicles and personnel, such as a life support ambulance, a non-ambulance transfer van staffed with two new emergency medical responders, six new emergency medical technicians, and a second paramedic response unit. These changes will boost the number of local EMS personnel by 20 per cent. The added resources will help meet peak call volume demands in the community and provide the right level of care for patient needs.

New physicians:

Physician recruitment efforts in southern Alberta continue to progress with the recent signing of new family physicians for the towns of Milk River and Bassano. AHS has recruited 70 physicians into the South Zone in 2014-15. Of those, 49 are practising and 21 physicians are in the process of completing education or assessment.

New magnetic resonance imaging:

In January 2015, work began to upgrade a new, state-of-the-art magnetic resonance imaging (MRI) scanner at the Medicine Hat Regional Hospital which will improve patient care by providing higher-quality images in less time. The new MRI scanner will help gain efficiencies in throughput with new imaging options. As well, it has a more comfortable design and is more spacious, capable of accommodating larger patients.

First two phases emergency department completed:

Patients can now enjoy additional private treatment areas with the completion of renovations to the emergency department at Chinook Regional Hospital. The five-phase project will increase the current emergency department floor space by about 30 per cent, including larger treatment room for trauma patients, four smaller acute treatment rooms, two secure psychiatry treatment rooms, additional workspaces for physicians and staff, and equipment storage. The first two phases were completed in 2014-15. The entire project is expected to be completed in 2017.

Serving by understanding spiritual beliefs:

For Low-German speaking Mennonites (LGM) living in southern Alberta, access to health care is often limited by language and cultural barriers. South Zone has community health representatives to help improve the health of these families. They provide education sessions on various health topics, including immunization, healthy living, and women's health. During the measles outbreaks in 2013 and 2014, they were instrumental in increasing the measles immunization rate in LGM families. They also collaborate directly with schools, public health nurses, social workers and other community partners to plan programs to address LGM health needs.

Nurse practitioners in continuing care:

In February 2015, specially trained registered nurses were placed within two local continuing care facilities as part of a pilot project designed to provide timely, on-site care to residents and reduce the need for emergency department visits. St. Therese Villa and St. Michael's Health Centre – both operated by Covenant Health – have each expanded their care teams to include a nurse practitioner. These nurses have advanced education that enables them to diagnose and treat health conditions, order tests and prescribe medications. Nurse practitioners also provide health promotion, disease prevention, health education and counselling.

SOUTH ZONE At a Glance

South Zone Population:

2014: 298,169

2024: 332,905

Land Mass: 65,500 km²

Aging Population:

2014: **42,363**
people were over the age of 65.

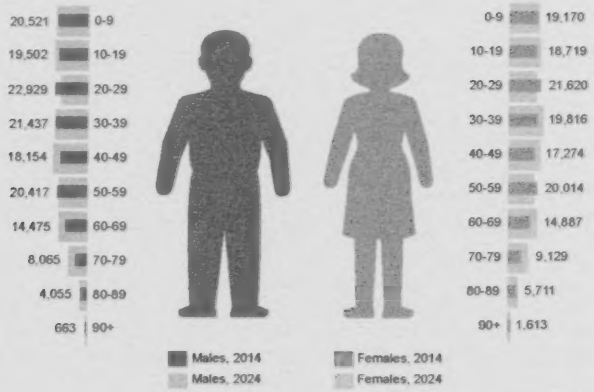
2024: **59,631**
people will be over the age of 65.

Female Population, 15-49 Years:

2014: **68,413**
women were of childbearing age (15-49 years).

2024: **74,375**
women will be of childbearing age (15-49 years).

South Zone Population Growth by Age (yrs):



Data Source:
2014 Alberta Provincial Registry data

SOUTH ZONE Facts at Your Fingertips

• 27.3% who are obese • 19.3% who smoke daily • 41.9% who eat 5 or more servings of fruit/ vegetables daily • 55.5% who are active or moderately active • 19.6% who are heavy drinkers *(≥ 5 drinks on one occasion, at least once a month)* • Life Expectancy: 79.9 years • Median Age: 36.2 years • Seniors Population: 14.2% who are 65 years old and older • Hospitals: 14

South Zone Quick Facts	2011-12	2012-13	2013-14	2014-15	% Change 2013-14 to 2014-15	% of Province
Primary Care / Population Health						
Home Care Clients	10,809	11,144	11,577	12,044	4.0%	10.5%
Number of People Placed in Continuing Care	976	930	868	866	-0.2%	11.1%
Health Link Calls	28,123	28,077	32,186	32,108	-0.2%	3.9%
Seasonal Influenza Immunizations	71,492	75,488	89,634	96,663	7.8%	7.7%
Food Safety Inspections	7,922	9,014	8,402	8,609	2.5%	9.3%
Acute Care						
Emergency Department Visits (all sites)	199,615	202,797	196,577	194,352	-1.1%	8.9%
Hospital Discharges	31,332	31,640	31,093	31,125	0.1%	7.8%
Births	3,949	4,124	3,973	4,156	4.6%	7.7%
Total Hospital Days	195,283	197,445	199,672	212,020	6.2%	7.5%
Average Length of Stay (in days)	6.2	6.2	6.4	6.8	6.4%	n/a
Diagnostic / Specific Procedures						
Total Hip Replacements (scheduled and emergency)	501	513	526	571	8.6%	10.6%
Total Knee Replacements (scheduled and emergency)	852	832	804	822	2.2%	12.9%
Cataract Surgery	2,769	2,514	2,653	2,878	8.5%	7.8%
Main Operating Room Activity	22,564	22,396	23,049	24,189	4.9%	8.7%
MRI exams	13,643	13,875	13,380	14,227	6.3%	7.1%
CT exams	22,917	22,724	24,906	26,185	5.1%	6.8%
X-rays	160,650	151,898	156,503	163,095	4.2%	8.7%
Lab Tests	4.5 M	4.6 M	4.8 M	5.1 M	5.0%	6.9%
Cancer Care						
Cancer Patient Visits (patients may have multiple visits)	30,696	32,645	31,529	30,277	-4.0%	5.2%
Unique Cancer Patients	4,729	4,775	4,522	4,349	-3.8%	8.3%
Addiction & Mental Health						
Mental Health Hospital Discharges (acute care sites)	2,043	2,038	2,019	2,026	0.3%	9.5%
Staffing						
Head Count	6,662	6,874	6,947	7,238	4.2%	7.2%
Volunteers	2,831	2,433	2,130	1,933	-9.2%	12.4%
AHS Physicians	n/a	n/a	n/a	704	n/a	9.1%

2014-15 | CALGARY ZONE HIGHLIGHTS

A registered nurse at the South Health Campus Emergency Department dons personal protective equipment (PPE) during an Ebola training exercise. In addition to numerous staff information sessions, several sites have conducted patient simulations like this one.

AHS uses Ebola scenarios to train health teams

An actor posing as a patient walks into the emergency department at South Health Campus, claiming he recently returned from West Africa and has influenza-like symptoms.

The triage team – unaware this 'patient' is an actor – launches into action. The training exercise has begun.

South Health Campus conducted two live scenario Ebola virus disease (EVD) training exercises in Fall 2014 as part of ongoing provincial EVD preparedness efforts.

"The goal of the exercise is to ensure our health care teams know how to react in the unlikely event that we get a case of Ebola in our province. It involves co-ordinating a number of teams, from emergency department staff, to laboratory services, to cleaning and maintenance staff," says Dr. Francois Belanger, AHS' Vice President and Medical Director, Central and Southern Alberta.

"This is about ensuring we are prepared to care for the patient, prevent spread of the disease and ensure our staff, physicians and all patients are safe and secure."

Although the risk of Ebola in Alberta remains very low, AHS is prepared to protect the health of Albertans, with procedures and precautions in place, staff training and simulations. Several sites are conducting Ebola patient simulations like this one.

"Training scenarios give staff the opportunity to put theory into practise before they encounter a patient in real life," says Lori Anderson, Senior Operating Officer of South Health Campus.

Within one hour of walking through the door, the patient actor was identified by the emergency department triage team and placed in a specialized isolation room at the facility's intensive care unit.

Nurses and physicians wore required personal protective equipment, and followed highly specialized procedures to keep themselves and patients safe.

Along with comprehensive guidelines and protocols, training and practise opportunities continue to be offered to AHS staff and physicians across the province.

Principles learned from this exercise could be considered in management of other communicable diseases, and this example demonstrates how every member of the team works together for the patient, family and community.

CALGARY ZONE HIGHLIGHTS

Prize awarded for Community Welcome:

In March 2015, the Rockyview General Hospital was selected for the Patient and Family Centred Care (PFCC) Project Sharing Award Prize for 2014, from the PFCC Innovation Center at the University of Pittsburgh Medical Center. The prize was awarded for the *Community Welcome,* which is a bi-weekly, four-hour session where new employees are introduced to patient- and family-centered care through the sharing of stories, videos and tools, and encouraging PFCC through empathy, self-care and enhanced work practice.

Cardiac Hybrid Operating Room opens:

In October 2014, Foothills Medical Centre opened the Cardiac Hybrid Operating Room, offering rapid diagnosis and leading-edge care to patients with heart conditions. The state-of-the-art operating room is more than twice the size of a traditional operating room and combines the technology needed to perform both diagnostic imaging and surgical procedures. The suite allows multiple clinicians to perform safer, faster and less invasive cardiac procedures, and offers the opportunity to attend new procedures.

Volunteers – Patient and Family Advisors:

In 2014, a number of initiatives were started where the voice of patients is included in the planning, delivery and evaluation of health care services. Patient and family advisors are valued volunteers, and important leaders and partners in today's health care system. Through their example, they are encouraging greater collaboration between patients, families and health care providers at all levels.

South Health Campus selected as Exemplar Hospital:

In June 2014, South Health Campus was one of 12 hospitals selected by the Institute for Patient- and Family-Centered Care as an exemplar in a new campaign, *Better Together: Partnering with Families* which focuses on changing restrictive visiting policies. South Health Campus was recognized during the campaign's launch as a leader for developing visiting policies reflective of a patient- and family-centered culture where family presence is recognized as essential to patients' health and well-being, and where they are respected allies for quality and safety.

Opening community health centre:

The Chestermere Community Health Centre opened in January 2015, bringing together home care, public health and mental health under one roof to create a comprehensive community health centre. The new facility also includes laboratory services.

Robots help patients:

In February 2015, four childlike robots were introduced to comfort young patients during stressful medical procedures at Alberta Children's Hospital. A first in Canada, the two-foot-tall robots, named MEDi (Medicine and Engineering Designing Influence), are programmed to mimic the actions of a child and to calm young patients with small talk and high fives during procedures, such as blood tests. A recent study showed children who interacted with the robots reported 50 per cent less pain compared to youngsters who received their procedure with little or no distraction.

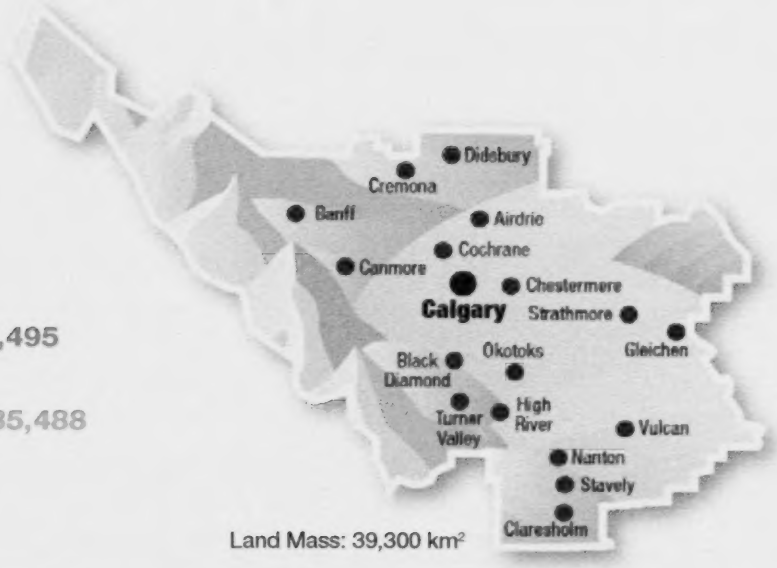
Community paramedics:

In 2014, 4,000 patients were seen in their homes within the community. This program was established to provide mobile primary and urgent health care to patients. Working in collaboration with physicians, community paramedics provided diagnostics and treatments in the home. These assessments and treatments bridged care for many high-needs patients in the community resulting in an estimated 3,200 emergency medical services and emergency department avoidances. New partnerships with Tom Baker Cancer Centre and Foothills Primary Care Network have further extended the program's ability to provide same-day care to more people in the community.

New continuing care capacity:

Since April 1, 2014, there was significant growth in continuing care capacity in Calgary Zone, with the addition of approximately 629 continuing care beds, including 148 long-term care spaces. These new spaces help match health services to seniors' needs in a manner that promotes wellness, independence and choice. The addition of these spaces in communities such as Didsbury, High River, Strathmore, northwest Calgary and southeast Calgary means that seniors will be able to have the greatest degree of independence closer to home.

CALGARY ZONE At a Glance



Land Mass: 39,300 km²

Calgary Zone Population:

2014: **1,544,495**

2024: **1,835,488**

Aging Population:

2014: **160,864**
people were over the age of 65.

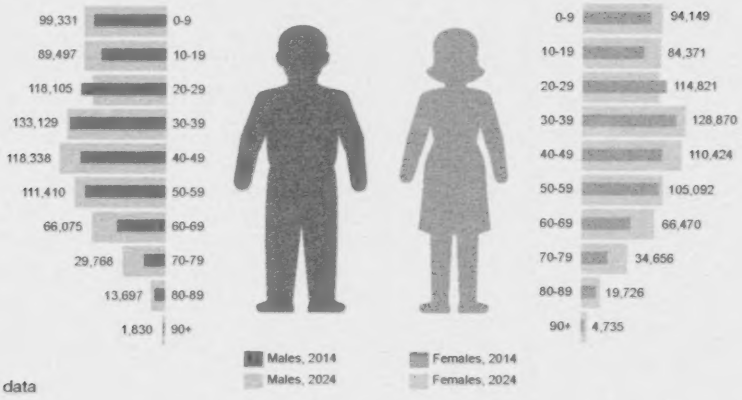
2024: **271,183**
people will be over the age of 65.

Female Population, 15-49 Years:

2014: **397,273**
women were of childbearing age (15-49 years).

2024: **440,869**
women will be of childbearing age (15-49 years).

Calgary Zone Population Growth by Age (yrs):



Data Source:
2014 Alberta Provincial Registry data

CALGARY ZONE Facts at Your Fingertips

• 14.9% who are obese • 13.2% who smoke daily • 44.3% who eat 5 or more servings of fruit/ vegetables daily • 59.1% who are active or moderately active • 23.8% who are heavy drinkers *(≥ 5 drinks on one occasion, at least once a month)* • Life Expectancy: 83.5 years • Median Age: 36.4 years • Seniors Population: 10.4% who are 65 years old and older • Hospitals: 14

Calgary Zone Quick Facts	2011-12	2012-13	2013-14	2014-15	% Change 2013-14 to 2014-15	% of Province
Primary Care / Population Health						
Home Care Clients	29,843	31,832	32,648	33,548	2.8%	29.2%
Number of People Placed in Continuing Care	2,059	2,301	2,164	2,548	17.7%	32.6%
Health Link Calls	317,142	319,859	325,215	325,566	0.1%	40.0%
Seasonal Influenza Immunizations	349,042	372,337	461,442	511,151	10.8%	40.7%
Food Safety Inspections	29,044	30,372	31,805	31,121	-2.2%	33.6%
Acute Care						
Emergency Department Visits (all sites)	417,774	450,901	485,803	493,811	1.6%	22.6%
Urgent Care Visits	179,500	185,706	181,377	183,209	1.0%	93.8%
Hospital Discharges	126,410	130,842	136,598	140,554	2.9%	35.0%
Births	18,024	18,452	18,865	19,554	3.7%	36.1%
Total Hospital Days	906,362	938,601	959,949	1,025,598	6.8%	36.5%
Average Length of Stay (in days)	7.2	7.2	7.0	7.3	4.2%	n/a
Diagnostic / Specific Procedures						
Total Hip Replacements (scheduled and emergency)	1,791	1,815	1,897	1,960	3.3%	36.3%
Total Knee Replacements (scheduled and emergency)	1,840	1,934	2,185	2,390	9.4%	37.5%
Cataract Surgery	13,498	13,131	13,799	13,678	-0.9%	37.2%
Main Operating Room Activity	88,927	90,211	94,403	97,177	2.9%	34.9%
MRI exams	57,967	64,061	75,273	78,175	3.9%	39.1%
CT exams	123,356	125,906	134,515	143,496	6.7%	37.1%
X-rays	524,229	520,147	539,337	541,087	0.3%	29.0%
Lab Tests	24.0 M	25.7 M	26.8 M	28.4 M	6.0%	38.5%
Cancer Care						
Cancer Patient Visits (patients may have multiple visits)	174,658	179,172	176,552	180,811	2.4%	31.3%
Unique Cancer Patients	19,642	20,646	20,926	21,717	3.8%	41.5%
Addiction & Mental Health						
Mental Health Hospital Discharges (acute care sites)	6,827	7,052	7,798	8,150	4.5%	38.0%
Staffing						
Head Count	33,444	35,839	35,909	37,000	3.0%	37.0%
Volunteers	3,726	4,686	4,165	4,623	11.0%	29.6%
AHS Physicians	n/a	n/a	n/a	3,076	n/a	39.7%

2014-15 | CENTRAL ZONE HIGHLIGHTS

Emergency medical technicians Pierre Sabourin (yellow jacket) and Michael VanderBaaren provide 24-hour emergency medical services to Nordegg and the surrounding area.

Full-time ambulance service in Nordegg

Starting in 2015, AHS began providing 24-hour emergency medical services to residents and visitors of Nordegg and the surrounding area. A dedicated ambulance will be based and staffed in the community to ensure the Nordegg area has around-the-clock access to emergency care.

"Nordegg's remote location provides some unique health care challenges that require a more consistent level of emergency medical coverage," says Lyle McKellar, Executive Director for Central Zone AHS Emergency Medical Services (EMS).

On average, EMS responds to nearly 100 calls a year in the Nordegg area, which supports vital forestry, mining, oil and gas, and recreational industries. Associated Ambulance has been contracted to provide 24-hour emergency medical services on behalf of AHS.

Associated is the largest contract provider in the province; it currently operates 21 ambulance stations, including one in Rocky Mountain House.

Ambulance service in Nordegg was historically provided by volunteers within the community. Over the last several years, it's been difficult recruiting and maintaining volunteers to provide the level of service required to support the community and surrounding area.

"We appreciate the commitment volunteers have shown in providing important emergency medical services to the community since 2010," says McKellar.

"Associated Ambulance is extending the opportunity to any current volunteers to be included in the casual pool to support the new service."

CENTRAL ZONE HIGHLIGHTS

Teamwork helps kids with developmental disabilities:

Camrose children with developmental disabilities and their families can now access expert diagnosis in their community thanks to the use of videoconferencing between the Glenrose Rehabilitation Hospital in Edmonton and the Camrose Pediatric Specialty Clinic. Since November 2014, developmental pediatricians at the Glenrose have been collaborating remotely with the Camrose team using AHS' Telehealth videoconferencing technology. This saves time, travel and expense for patients and families, and Glenrose doctors. It reduces delays and wait lists for kids to be served in their own community.

Surgical capacity expanded in Innisfail:

To serve residents in central Alberta, day surgery services were expanded to include plastic and retinal surgical services beginning in February 2015 at the Innisfail Health Centre. Nearly 450 plastic surgery procedures will be completed annually in addition to the existing cataract surgery program.

Olds Sunrise Encore opens additional living options:

As of February 2015, more local seniors are able to get the round-the-clock care and support they need in their community with the opening of 60 new supportive living beds at Sunrise Encore. The additional capacity will provide care to residents who have more complex needs (including dementia), while helping them remain in their community, close to friends and family.

One phone number to access continuing care services:

As of April 2014, residents in central Alberta can call a toll-free telephone number to access a wide range of continuing care services for themselves or their loved ones. The Continuing Care Access Centre connects callers to a team of AHS registered nurses who can discuss the caller's concerns, complete an initial assessment of the caller's situation and refer the caller to the appropriate community service(s), such as home care, supportive living, long-term care and even non-continuing care services. The toll-free number will also help physicians and other health providers in the Central Zone to secure timely access to appropriate care for seniors.

Aboriginal Cultural Room opens:

A newly dedicated space in the Wetaskiwin Hospital and Care Centre will provide a place of spiritual healing for Aboriginal patients and their families. The Aboriginal Cultural Room provides a quiet, comfortable space on the hospital's third floor where patients and families can gather with an Elder for prayer and traditional ceremonies, such as smudging. This cultural room will support the community of Maskwacis and its Four Band membership: Samson, Ermineskin, Louis Bull and Montana First Nations.

Expanded surgical program at Olds:

Decanting orthopedic and gynecology day surgery from Red Deer Regional Hospital to Olds Hospital and Care Centre increased patient access to those surgeries for local residents. This service change has also increased capacity for other surgical procedures at Red Deer.

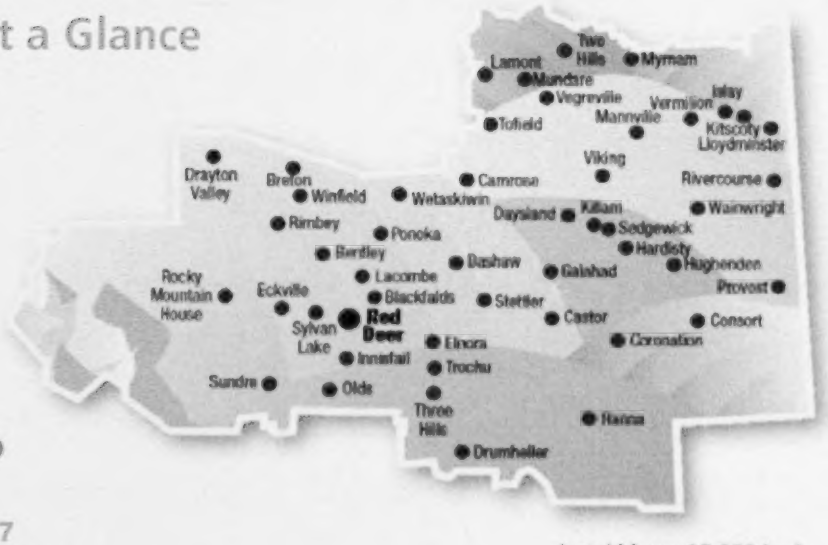
More dialysis patients are receiving treatment at home:

A push to train more patients to perform their own dialysis started in Summer 2014 after dialysis service at Red Deer Regional Hospital Centre was stretched beyond its 120-patient capacity. Two more dialysis chairs were also added at the hospital last summer bringing the total to 22 chairs, increasing dialysis capacity to 132 patients per week. The extra capacity gained with the two new stations, the overflow capacity as well as the expansion of home therapy, has made a real difference. Dialysis is a life-saving and a specialized service; the increase in access is helping to address the growing number of patients with chronic renal failure in the area.

Mental health collaborative received the Premier's Award for School Board Innovation and Excellence:

Journeys, an alternative school program in Red Deer, was recognized for serving youth with complex mental health and behavioural needs. Students in central Alberta between the ages of 11 and 18 are supported in their transition back to regular school programs through the collaborative effort between five school divisions, Central Alberta Child and Family Services, the City of Red Deer, RCMP and AHS.

CENTRAL ZONE At a Glance



Central Zone Population:

2014: **470,490**

2024: **523,237**

Land Mass: 95,000 km²

Aging Population:

2014: **64,931**
people were over the age of 65.

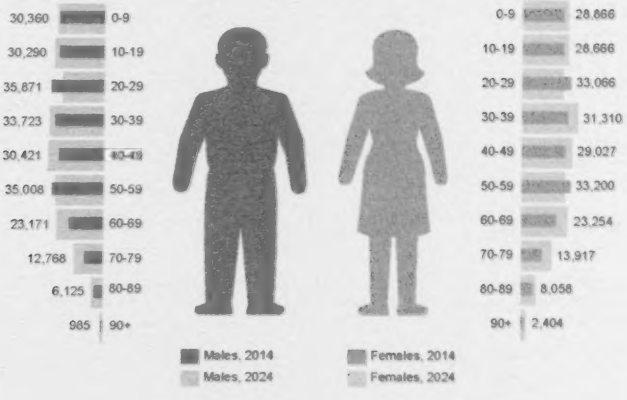
2024: **93,551**
people will be over the age of 65.

Female Population, 15-49 Years:

2014: **108,478**
women were of childbearing age (15-49 years).

2024: **115,701**
women will be of childbearing age (15-49 years).

Central Zone Population Growth by Age (yrs):



Data Source:
2014 Alberta Provincial Registry data

CENTRAL ZONE Facts at Your Fingertips

• 21.2% who are obese • 20.7% who smoke daily • 36.7% who eat 5 or more servings of fruit/vegetables daily • 54.5% who are active or moderately active • 22.9% who are heavy drinkers *(≥ 5 drinks on one occasion, at least once a month)* • Life Expectancy: 80.1 years • Median Age: 37.2 years • Seniors Population: 13.8% who are 65 years old and older • Hospitals: 30

Central Zone Quick Facts	2011-12	2012-13	2013-14	2014-15	% Change 2013-14 to 2014-15	% of Province
Primary Care / Population Health						
Home Care Clients	16,401	16,962	17,483	18,245	4.4%	15.9%
Number of People Placed in Continuing Care	1,313	1,281	1,189	1,259	5.9%	16.1%
Health Link Calls	58,500	58,686	57,847	62,035	7.2%	7.6%
Seasonal Influenza Immunizations	85,877	86,453	109,014	115,539	6.0%	9.2%
Food Safety Inspections	10,669	12,443	10,626	11,234	5.7%	12.1%
Acute Care						
Emergency Department Visits (all sites)	376,998	379,557	372,122	379,892	2.1%	17.4%
Hospital Discharges	45,675	45,619	44,589	45,647	2.4%	11.4%
Births	4,792	4,869	4,812	4,926	2.4%	9.1%
Total Hospital Days	321,855	319,977	322,478	330,302	2.4%	11.8%
Average Length of Stay (in days)	7.0	7.0	7.2	7.2	0.5%	n/a
Diagnostic / Specific Procedures						
Total Hip Replacements (scheduled and emergency)	496	566	574	569	-0.9%	10.5%
Total Knee Replacements (scheduled and emergency)	648	649	669	654	-2.2%	10.3%
Cataract Surgery	3,331	3,489	3,495	3,608	3.2%	9.8%
Main Operating Room Activity	28,275	27,967	28,012	29,330	4.7%	10.5%
MRI exams	13,388	12,204	13,137	12,610	-4.0%	6.3%
CT exams	32,074	31,575	33,708	36,143	7.2%	9.3%
X-rays	278,636	261,541	259,979	256,595	-1.3%	13.7%
Lab Tests	5.8 M	6.0 M	6.1 M	6.2 M	1.6%	8.4%
Cancer Care						
Cancer Patient Visits (patients may have multiple visits)	15,467	15,508	18,686	27,298	46.1%	4.7%
Unique Cancer Patients	2,004	2,001	2,172	2,461	13.3%	4.7%
Addiction & Mental Health						
Mental Health Hospital Discharges (acute care sites)	2,356	2,342	2,169	2,281	5.2%	10.6%
Staffing						
Head Count	11,784	12,210	12,361	12,631	2.2%	12.6%
Volunteers	3,136	3,296	3,297	3,292	-0.2%	21.1%
AHS Physicians	n/a	n/a	n/a	707	n/a	9.1%

2014-15 | EDMONTON ZONE HIGHLIGHTS

Nurse Emebet Begna assists mom Nicole Hareuther with baby Myles at the Lois Hole Hospital for Women in the Royal Alexandra Hospital.

The baby boom continues

Birth rates in the Edmonton Zone rose again in 2014. In the last year, there was an average of 53 babies born each day – enough to fill one yellow school bus. Through the year, there were 19,362 babies born in the five Edmonton Zone hospitals. Additionally, about 400 babies were born at home or in a birthing centre and attended to by registered midwives.

Compared to five years ago, births in the Edmonton Zone have grown by 14 per cent, that's 44 more school buses filled with children.

Though most of the mothers and babies cared for in the Edmonton Zone are at low risk for developing complications, hospitals also provide specialist care for high-risk obstetrics to mothers and babies. Patients come from not just the Edmonton Zone, but also from other parts of the province and other provinces and territories. While the majority of babies arrived when they were expected, 12 per cent (2,289 babies) were born early and required specialized care.

Babies in the Edmonton Zone arrived together, too—there were 375 sets of twins – about one set born every day. When added to the 10 sets of triplets, the multiple birth babies could fill almost 15 school buses on their own.

The five Edmonton Zone hospitals that deliver babies include the Fort Saskatchewan Community Hospital, the Sturgeon Community Hospital in St. Albert, the Covenant Health Misericordia Community Hospital, the Covenant Health Grey Nuns Community Hospital, and the Lois Hole Hospital for Women at the Royal Alexandra Hospital.

Edmonton Zone's health professionals are proud to have the opportunity to contribute to the health and well-being of Alberta's newest and smallest citizens.

EDMONTON ZONE HIGHLIGHTS

Paramedics and mental health professionals partner to offer crisis help in the community:

In February 2015, Crisis Response and Emergency Medical Services started a pilot project that teams a paramedic and a mental health therapist/nurse. The team works collaboratively with mental health crisis services and other addiction and mental health programs by effectively engaging clients to meet their needs and provide treatment in the community thereby avoiding unnecessary trips to the emergency department.

Triple Aim improves health status and reduces strain on health system:

The Triple Aim quality improvement approach improves the health status and the experience of care and reduces health care costs for people with significant complex health needs in the inner city, many of whom are homeless. In August 2012, six teams in Edmonton began working with individuals in the inner city. Since then, there has been an increase in patients' well-being and a reduction in emergency department use. Recent data shows that the Triple Aim approach has resulted in a decrease in emergency department use after the first few months of intervention.

Doctors pioneer life-saving heart transplant protocol:

In July 2014, doctors at Stollery Children's Hospital in Edmonton, together with University of Alberta researchers, presented the successful outcomes of three pediatric heart transplants using an anti-rejection therapy similar to one sometimes used in adults awaiting kidney transplants. The Stollery is the first and only pediatric academic health centre in Canada to successfully use the treatment which combines a common agent used to treat cancer with a blood plasma therapy that slows a child's immune response to prevent the donor organ from being rejected.

Surgical team breaks Alberta's transplant record:

In July 2014, Edmonton surgeons set a new Alberta transplant record, performing more transplants over a 10-day period than they normally do in a month.

The transplant services team at the University of Alberta Hospital performed 32 organ transplants between July 18 and 27: three lung, four heart, eight liver, five islet, one whole pancreas, one kidney/pancreas and 10 kidney transplants. Surgeons at the AHS facility typically perform between 20 and 25 organ transplants per month.

Local liver transplant program celebrates 25 years:

Edmonton is home to the second busiest liver transplant program in Canada. More than 1,400 individuals, mostly from Alberta and western Canada, have received new livers through the program based at the University of Alberta Hospital. The program has driven quality that has significantly improved patient outcomes and survival rates over the past quarter-century.

New outpatient clinic opens:

In August 2014, pediatric patients and their families have improved access to specialty health services with the opening of the Edmonton Oilers Ambulatory Clinic at the Stollery Children's Hospital. Designed with a focus on family-centred care, the new space supports the shift in care delivery from inpatient to outpatient care and allows for a 30 per cent growth in the volume of children served. The new facility brings under one roof more than 40 clinic services — previously located at different AHS sites — which will enable patients to see multiple specialists during a single visit.

Phase 1 Edmonton Zone 2030 Plan released:

AHS has undertaken a comprehensive planning process to look at health services and infrastructure supports required to meet the current and future health needs of the Edmonton Zone into the year 2030. Once completed, the Edmonton Zone 2030 Plan will be the first long-term plan created for the Edmonton Zone since the creation of the current AHS Zone structure in 2011. This work involves planning for services, resources and physical structures to meet the needs of the Edmonton Zone and also serves as a guide as AHS starts similar planning processes for other zones. Phase 1 includes a snapshot of the current condition and inventory of 18 facilities in the Edmonton Zone and looks at potential short-term strategies to the year 2015-16, to improve service delivery and relieve capacity pressures at the 18 facilities.

EDMONTON ZONE At a Glance

Edmonton Zone Population:

2014: **1,295,164**

2024: **1,525,924**

Land Mass: 11,800 km²

Aging Population:

2014: **149,944**
people were over the age of 65.

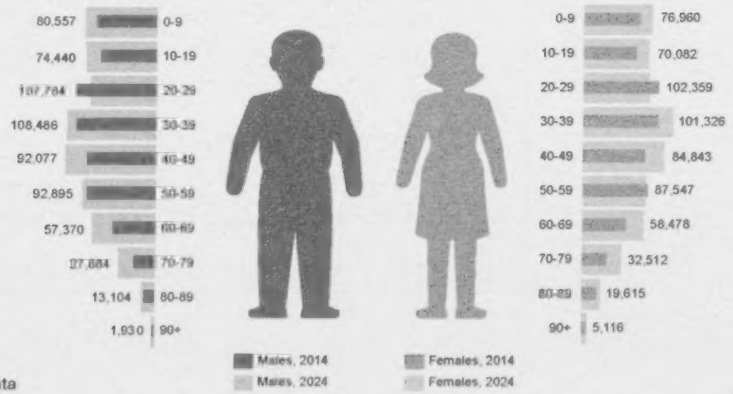
2024: **234,762**
people will be over the age of 65.

Female Population, 15-49 Years:

2014: **325,300**
women were of childbearing age (15-49 years).

2024: **363,183**
women will be of childbearing age (15-49 years).

Edmonton Zone Population Growth by Age (yrs):



Data Source:
2014 Alberta Provincial Registry data

EDMONTON ZONE Facts at Your Fingertips

• 19.8% who are obese • 12.7% who smoke daily • 43.1% who eat 5 or more servings of fruit/vegetables daily • 57.2% who are active or moderately active • 15.0% who are heavy drinkers *(≥ 5 drinks on one occasion, at least once a month)* • Life Expectancy: 81.9 years • Median Age: 36.1 years • Seniors Population: 11.6% who are 65 years old and older • Hospitals: 14

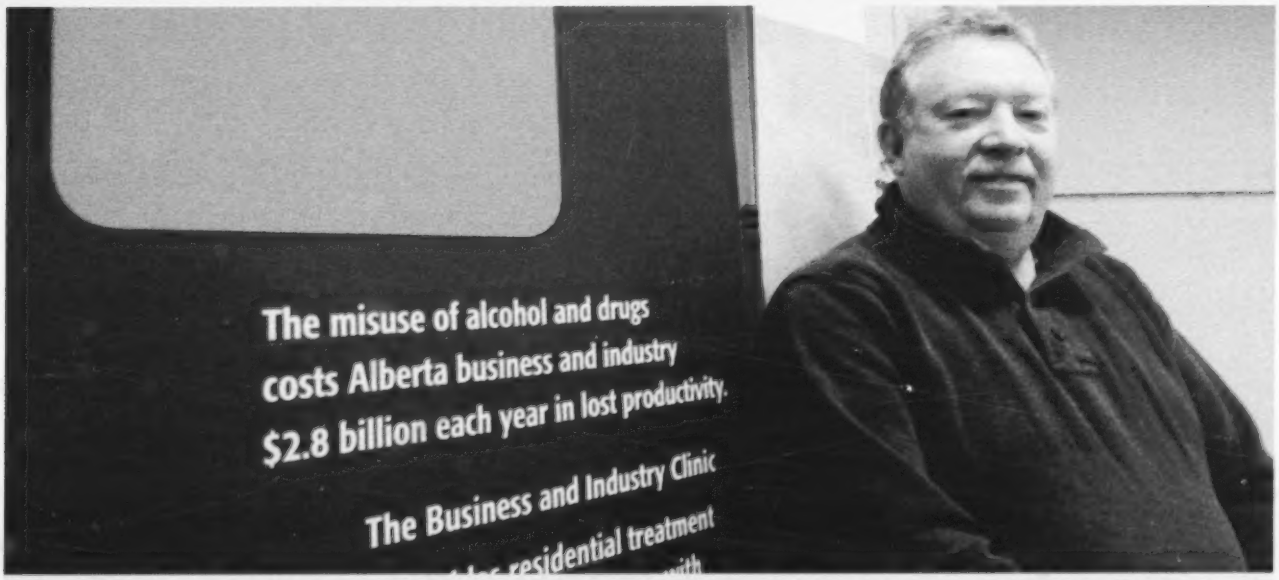
Edmonton Zone Quick Facts	2011-12	2012-13	2013-14	2014-15	% Change 2013-14 to 2014-15	% of Province
Primary Care / Population Health						
Home Care Clients	36,485	37,604	38,011	38,183	0.5%	33.2%
Number of People Placed in Continuing Care[1]	2,790	2,620	2,742	2,443	-10.9%	31.3%
Health Link Calls	294,222	283,410	296,362	325,440	9.8%	40.0%
Seasonal Influenza Immunizations	282,703	298,712	387,959	417,388	7.6%	33.3%
Food Safety Inspections[2]	27,316	28,234	29,678	26,170	-11.8%	28.2%
Acute Care						
Emergency Department Visits (all sites)	455,938	492,014	502,838	534,889	6.4%	24.5%
Urgent Care Visits[3]	16,768	18,896	23,977	12,022	-49.9%	6.2%
Hospital Discharges	128,515	132,337	135,970	139,053	2.3%	34.7%
Births	17,414	17,848	18,374	19,258	4.8%	35.5%
Total Hospital Days	932,357	933,710	940,976	984,396	4.6%	35.1%
Average Length of Stay (in days)	7.3	7.1	6.9	7.1	2.6%	n/a
Diagnostic / Specific Procedures						
Total Hip Replacements (scheduled and emergency)	1,832	2,040	1,936	1,958	1.1%	36.3%
Total Knee Replacements (scheduled and emergency)	2,154	2,305	2,156	2,068	-4.1%	32.4%
Cataract Surgery	14,935	14,480	14,525	14,410	-0.8%	39.2%
Main Operating Room Activity	103,954	104,768	105,553	104,254	-1.2%	37.4%
MRI exams	69,507	73,570	75,665	81,945	8.3%	41.0%
CT exams	125,571	133,007	139,743	147,226	5.4%	38.0%
X-rays	594,459	585,759	597,028	609,179	2.0%	32.6%
Lab Tests	24.7 M	25.7 M	26.8 M	27.1 M	1.3%	36.7%
Cancer Care						
Cancer Patient Visits (patients may have multiple visits)	313,891	320,344	319,104	325,538	2.0%	56.3%
Unique Cancer Patients	22,169	22,769	23,507	23,868	1.5%	45.6%
Addiction & Mental Health						
Mental Health Hospital Discharges (acute care sites)	5,623	5,861	6,061	5,978	-1.4%	27.9%
Staffing						
Head Count	29,617	31,380	31,497	32,657	3.7%	32.7%
Volunteers	2,871	3,052	2,522	2,680	6.3%	17.2%
AHS Physicians	n/a	n/a	n/a	2,659	n/a	34.3%

[1] The decrease in the Number of People Placed in Continuing Care is attributed to the opening of restorative beds.

[2] Inspections decreased as staff resources were needed for E.Coli outbreak.

[3] Urgent care visits decreased due to the closure of Health First Strathcona; emergency department visits increased due to the opening of the new Strathcona Community Hospital in May 2014.

2014-15 | NORTH ZONE HIGHLIGHTS


The misuse of alcohol and drugs
costs Alberta business and industry
$2.8 billion each year in lost productivity.
The Business and Industry Clinic

Ian McGregor is one of the many people who received help to get sober through the Business and Industry Clinic at the Northern Addictions Centre. In 2014, the clinic celebrated its 20th anniversary.

Business and Industry Clinic celebrates 20 years

His name is Ian McGregor, and he is an addict. But, McGregor has been clean and sober for nearly two decades after taking part in the Business and Industry Clinic at the Northern Addictions Centre (NAC).

"I tried to quit using before but was unsuccessful," recalls McGregor, now a 52-year-old father of two teenage boys. "I didn't really take it seriously until after my first son was born."

McGregor was one of the first clients to take part in the unique program that gives employers a chance to help employees struggling with addictions issues, empowering them to get and stay sober.

The Business and Industry Clinic marked its 20th anniversary in 2014. Manager of the program for its first 11 years, David Nesbitt had been at the NAC for just over a year when its management team began working on something new. Prompted by requests from the business community, the task was to develop an addictions treatment program addressing substance abuse in the workplace and its effects on a booming province.

"It wasn't about just the treatment of the individual, it was also about providing for a safe workplace," says Nesbitt, now retired. "We wanted to create a win-win situation for the employee that was in trouble, but also for the organization that had a mandate to create a safe workplace for its employees — a safe workplace that would ultimately impact the public as well."

There are two programs offered through the Business and Industry Clinic, each embracing a 12-step philosophy: the 30-day alcohol and drug program and the 50-day cocaine program. Both incorporate group therapy, psycho-educational workshops, a family participation component, one-on-one case management and extensive follow-up after clients leave.

The Business and Industry Clinic has accepted clients from 18 to over 70 years old, but McGregor says sooner is better. He urges anyone struggling with addiction to take the steps needed to get clean now. "You've wasted enough of your life," he says. "It's simple — if you know you have a problem, it's time to do something about it."

NORTH ZONE HIGHLIGHTS

New service born in High Level:

A new service is now available for moms-to-be in the High Level area. The first midwife in the northwest area began offering care in April 2014, giving local families another option for their prenatal, delivery and post-partum care. Working closely with physicians and administration at the Northwest Health Centre, a set of midwifery-related policies and procedures were developed to support the new service.

Doctor recruitment:

AHS is making progress on its goal to increase access to primary care services in High Prairie with the arrival of new physicians in 2014-15. As part of an overall physician recruitment strategy, AHS has three North Zone physician resource planners who identify and pursue physician recruitment opportunities. The physician resource planners work collaboratively with various community partners and organizations in northern Alberta, such as the Rural Physician Action Plan, Health Advisory Councils, and independent community physician recruitment and retention committees.

Whitecourt teens YOLO into active lifestyles:

In the spring of 2014, AHS staff introduced the Whitecourt YOLO (You Only Live Once) program after discussions with local teachers highlighted the need for more options for teens to be active and live a healthy lifestyle, beyond the usual organized sports. The seven-week program runs twice a week with each session starting with a 15-minute education session and then a 45-minute exercise session where teens try out a wide range of activities. The program ends with participants cooking a healthy meal for their families and getting a six-month membership to a local fitness centre to continue their activity. The project has been a success, and sessions will start in other schools.

Patient and family engagement:

The official opening of the Intensive Care Unit (ICU) Family Waiting Room in the Queen Elizabeth II Hospital in Grande Prairie took place during the Family- and Patient-Centred Care Week in Fall 2014. The room enables family members with critically ill patients in the ICU to rest and reenergize while being close to their loved ones.

eSIM North:

In November 2014, Grande Prairie celebrated the opening of a new eSimulation Space for the eSIM (Education, Simulate, Innovate, Motivate) Program. The centre has three medical mannequins that can be used to train health care staff, so they are prepared for real-life situations. The mannequins have lifelike breathing and chest movements and speak. Simulations can include medical emergencies, injections and having a baby. Many departments in the hospital, such as respiratory therapy, lab and diagnostic imaging, can be involved in this training. The specialized simulators help health care workers improve safety and quality.

Patients first:

Patients at the Queen Elizabeth II Hospital have a more seamless experience when they arrive at the facility thanks to improvements launched in July 2014 at patient registration. Patients are now registered in a single process, by taking a number and then waiting to be called on by registration staff. Taking a number not only eliminates previous lineups that formed at the front door, but also eliminates that first step of waiting in line and provides more privacy for patients. Patients now only have to see the registration staff one time, and with the number system, patients feel better that they will not miss their place in line.

Changes to pharmacy order process save time:

Northern Lights Regional Health Centre applied training received from AHS Improvement Way (AIW) to improve medication deliveries to nursing units. A group of pharmacists and nurses discovered that medication orders took about 129 minutes between pickup and delivery to the units, but only 10 minutes of that time was spent working on the order. For the other 119 minutes, orders were waiting in various queues to be filled. The team worked with Information Technology and AIW staff to develop an efficient electronic solution to the problem. A new system was developed where nurses scanned and emailed their orders to pharmacy – avoiding time wasted to physically gather requests from each floor. Other efficiencies included a centralized location for medications. Collectively, these changes increased the number of morning orders able to be prepared by delivery time by 31 percent.

NORTH ZONE At a Glance

Land Mass: 448,500 km²

North Zone Population:

2014: **478,979**

2024: **547,526**

Aging Population:

2014: **42,843**
people were over the age of 65.

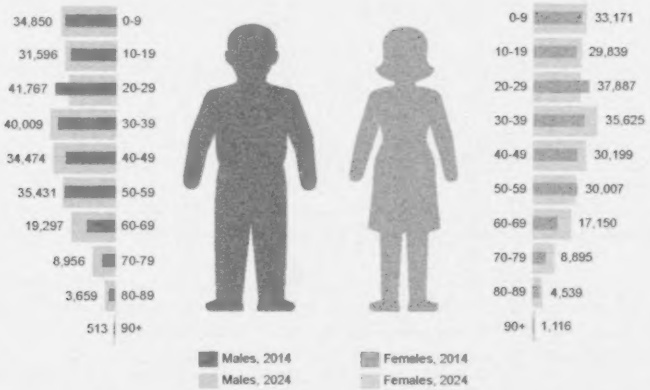
2024: **72,186**
people will be over the age of 65.

Female Population, 15-49 Years:

2014: **119,179**
women were of childbearing age (15-49 years).

2024: **128,795**
women will be of childbearing age (15-49 years).

North Zone Population Growth by Age (yrs):



Data Source:
2014 Alberta Provincial Registry data

NORTH ZONE Facts at Your Fingertips

• 27.4% who are obese • 21.5% who smoke daily • 41.0% who eat 5 or more servings of fruit/vegetables daily • 56.2% who are active or moderately active • 23.1% who are heavy drinkers *(≥ 5 drinks on one occasion, at least once a month)* • Life Expectancy: 79.7 years • Median Age: 33.7 years • Seniors Population: 8.9% who are 65 years old and older • Hospitals: 34

North Zone Quick Facts	2011-12	2012-13	2013-14	2014-15	% Change 2013-14 to 2014-15	% of Province
Primary Care / Population Health						
Home Care Clients	10,978	11,642	12,343	12,970	5.1%	11.3%
Number of People Placed in Continuing Care	562	629	731	694	-5.1%	8.9%
Health Link Calls	68,159	65,948	66,743	68,322	2.4%	8.4%
Seasonal Influenza Immunizations	86,870	86,358	109,501	114,209	4.3%	9.1%
Food Safety Inspections	13,462	14,793	14,878	15,589	4.8%	16.8%
Acute Care						
Emergency Department Visits (all sites)	578,900	591,677	585,294	577,637	-1.3%	26.5%
Hospital Discharges	44,186	45,098	45,515	44,900	-1.4%	11.2%
Births	5,918	6,247	6,299	6,309	0.2%	11.6%
Total Hospital Days	246,551	250,804	247,759	256,027	3.3%	9.1%
Average Length of Stay (in days)	5.6	5.6	5.4	5.7	5.6%	n/a
Diagnostic / Specific Procedures						
Total Hip Replacements (scheduled and emergency)	292	282	310	340	9.7%	6.3%
Total Knee Replacements (scheduled and emergency)	342	396	410	445	8.5%	7.0%
Cataract Surgery	2,026	2,102	2,313	2,192	-5.2%	6.0%
Main Operating Room Activity	22,883	23,038	23,478	24,189	3.0%	8.7%
MRI exams	12,140	12,995	12,569	12,971	3.2%	6.5%
CT exams	30,696	31,455	32,309	34,066	5.4%	8.8%
X-rays	311,335	296,496	295,275	298,088	1.0%	16.0%
Lab Tests	4.6 M	4.7 M	4.8 M	4.9 M	2.3%	6.6%
Cancer Care						
Cancer Patient Visits (patients may have multiple visits)	13,260	13,956	14,469	14,081	-2.7%	2.4%
Unique Cancer Patients	2,015	2,121	2,272	2,199	-3.2%	4.2%
Addiction & Mental Health						
Mental Health Hospital Discharges (acute care sites)	2,429	2,662	2,961	2,994	1.1%	14.0%
Staffing						
Head Count	9,898	9,804	9,987	10,411	4.2%	10.4%
Volunteers	4,200	4,482	3,356	3,083	-8.1%	19.7%
AHS Physicians	n/a	n/a	n/a	579	n/a	7.5%

ABOUT AHS - WHO WE ARE

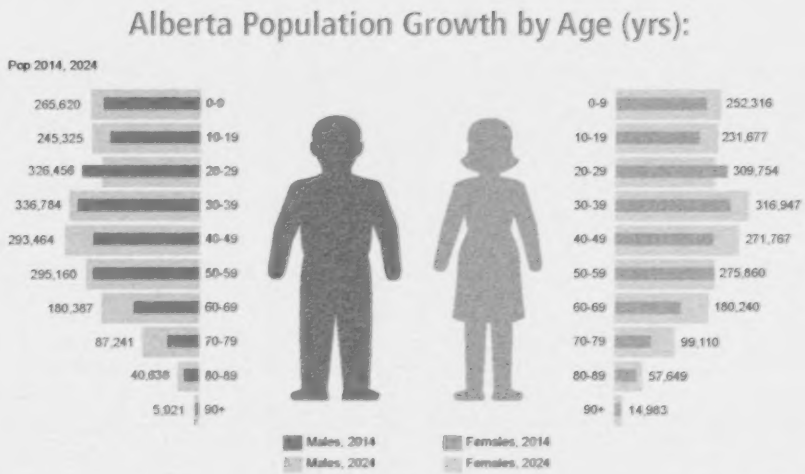
Alberta Health Services (AHS) is Canada's first and largest provincewide, fully-integrated health system, responsible for delivering health services to the over four million people living in Alberta, as well as to some residents of Saskatchewan, B.C. and the Northwest Territories. Alberta is the fastest-growing province in Canada. In 2014, Alberta's population growth rate more than doubled the national average (2.9 per cent and 1.1 per cent, respectively).

Albertans born in 2014 are expected to live to 81.8 years of age; that's up from 79.6 years expected for Albertans born in 2000. As we age, we depend more on the health care system. Within 15 years, one in five Albertans is expected to be 65 or older.

Along with a growing population, Alberta is becoming a community with an increasingly diverse population. Alberta has large rural and some remote populations. Certain geographical areas within our province are comprised of different ethnicities, different population structures and unique health needs requiring tailored approaches to health care delivery. We must better understand and respond to the health needs of our diverse populations. Patient, family and community engagement is critical to gaining the understanding that will improve the health system and result in better health for all Albertans.

AHS is organized by five zone geographic areas which are designed to better focus our attention on providing high-quality health care to Albertans. Our zones — South, Calgary, Central, Edmonton and North — enable local decision-making and engagement with local communities, local staff members, and our patients and clients.

Provincewide services, such as emergency medical services; population, public and aboriginal health; diagnostic imaging; quality and safety; and so on, work in cooperation with the zones to deliver care.

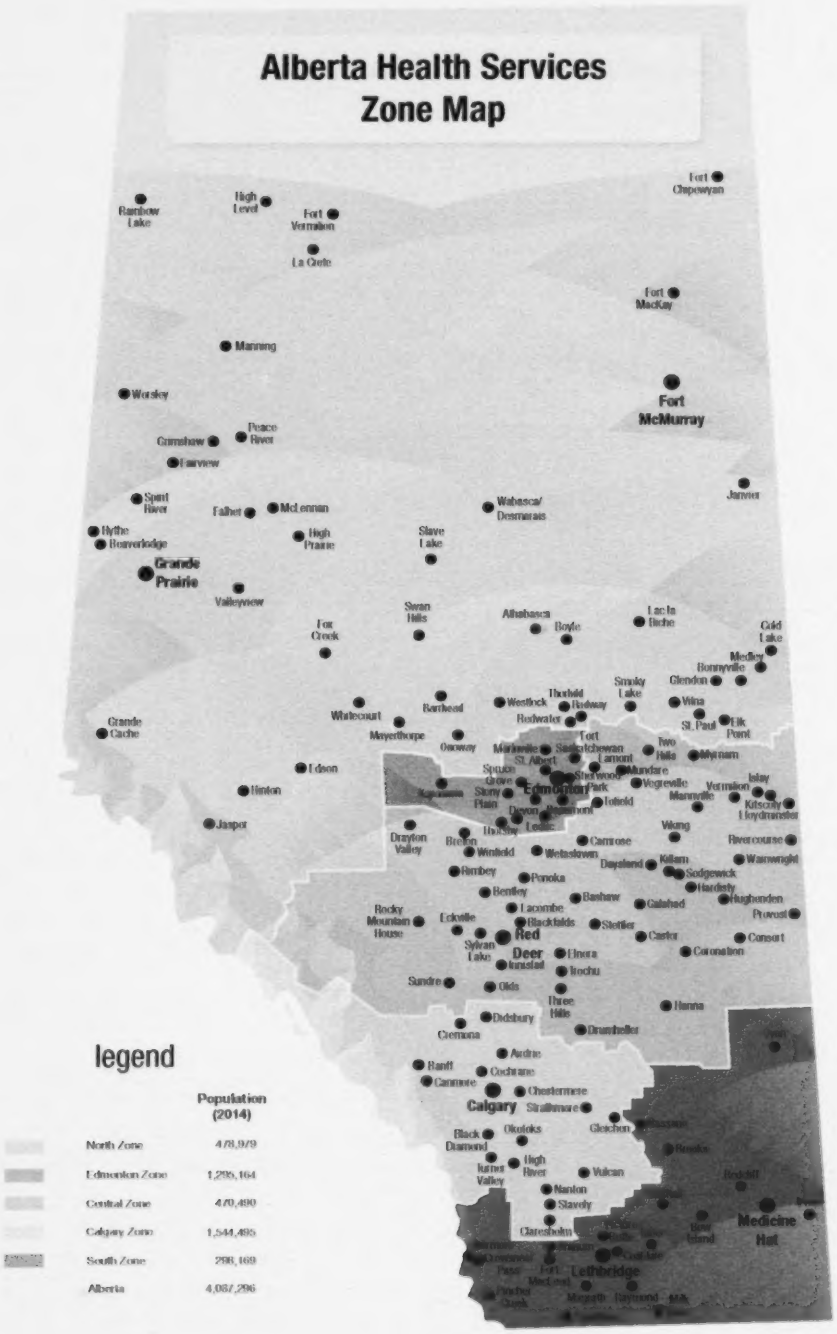


AHS has more than 108,000 employees, including over 99,900 direct AHS employees (excluding Covenant Health staff) and over 8,200 staff working in AHS wholly-owned subsidiaries, such as Carewest, CapitalCare Group and Calgary Laboratory Services. We are also supported by over 15,600 volunteers and almost 9,300 physicians practising in Alberta, more than 7,700 of whom are members of the AHS medical staff (physicians, dentists, podiatrists, oral and maxillofacial surgeons).

Students from Alberta's universities and colleges, as well as from universities and colleges outside of Alberta, receive clinical education in AHS facilities and community locations.

AHS programs and services are offered at more than 650 facilities throughout the province, including hospitals, clinics, continuing care facilities, cancer centres, mental health facilities and community health sites. We also have an extensive network of community-based services designed to assist Albertans maintain and/or improve health status.

ALBERTA HEALTH SERVICES MAP



MISSION, VALUES AND STRATEGIC DIRECTIONS

Mission

The mission of Alberta Health Services is to provide a patient-focused, quality health system that is accessible and sustainable for all Albertans

Values

AHS core values define what we believe in and what we stand for. They guide the decisions we make in relation to our mission and strategic directions, and they anchor our work and actions in a common understanding of what is important.

Respect: We demonstrate respect for one another, our patients, clients, communities and partners as we lead the evolution of health care.

Accountability: We display integrity; act honestly; and evaluate and improve the quality, safety and effectiveness of our services and the outcomes of our decisions. We use best practice to promote excellence, innovation and continuous improvement.

Transparency: We value open, honest and timely communication. We disclose information to learn from our mistakes; make available easy-to-understand information about system and financial performance; and clearly lay out our expectations and decision-making processes.

Engagement: We collaborate with patients and their families, health care providers, research and education institutions, government and communities, and involve them in meaningful ways.

Safety: We actively promote the safety and wellness of our communities, clients and patients. We can only achieve long-term success if we promote the workplace safety and well-being of our staff, physicians and volunteers.

Learning: We seek the best information available and find ways to use it in our daily work. Learning to be the best also means supporting and promoting the development of new knowledge.

Performance: We perform at our highest potential when every person in AHS has a clear and well-understood responsibility to improve their areas of performance every day.

Strategic Directions

Alberta Health and AHS have worked together to improve patient experience and quality of care, health outcomes, and the sustainability of the health care system. AHS has three strategic directions with goal statements:

Bringing Appropriate Care to the Community

Build a strong integrated community and primary care foundation to deliver appropriate, accessible and seamless care.

Partnering for Better Outcomes

Actively engage Albertans as partners and provide them with the support they need to enhance control over the factors that affect their health and the health of their families.

Advance the adoption of evidence-informed practices in the delivery of quality services across the continuum through partnerships with providers, academic institutions, physicians and others.

Achieving Health System Sustainability

Continue to build a sustainable, quality health system that is patient-centred, driven by outcomes and informed by evidence.

PROVINCIAL QUICK FACTS

The numbers below provide a snapshot of Alberta Health Services' activity and demonstrate the growth in services provided in the last few years.

Alberta Health Services	2011-12	2012-13	2013-14	2014-15	% Change 2013-14 to 2014-15
Community Ambulatory Care					
Home Care Clients	104,516	109,184	112,062	114,990	2.6%
Number of People Placed in Continuing Care	7,700	7,761	7,694	7,810	1.5%
Health Link Calls	766,146	755,980	778,353	813,471	4.5%
Seasonal Influenza Immunizations	875,984	919,348	1,157,550	1,254,950	8.4%
EMS Calls / Events	393,964	416,160	461,813	503,769	9.1%
Food Safety Inspections	88,413	94,856	95,389	92,723	-2.8%
Acute Care					
Emergency Department Visits (all sites)	2,029,225	2,116,946	2,142,634	2,180,581	1.8%
Urgent Care Visits	196,268	204,602	205,354	195,231	-4.9%
Hospital Discharges	376,118	385,536	393,765	401,279	1.9%
Births	50,097	51,540	52,323	54,203	3.6%
Total Hospital Days	2,602,408	2,640,537	2,670,834	2,808,343	5.1%
Average Length of Stay (in days)	6.9	6.8	6.8	7.0	2.9%
Diagnostic / Specific Procedures					
Total Hip Replacements (scheduled and emergency)	4,912	5,216	5,243	5,398	3.0%
Total Knee Replacements (scheduled and emergency)	5,836	6,116	6,224	6,379	2.5%
Cataract Surgery	36,559	35,716	36,785	36,766	-0.1%
Main Operating Room Activity	266,603	268,380	274,495	278,451	1.4%
MRI Exams	166,645	176,705	190,024	199,928	5.2%
CT Exams	334,614	344,667	365,181	387,116	6.0%
X-rays (in millions)	1.9 M	1.8 M	1.8 M	1.9 M	1.1%
Lab Tests (in millions)	65.5 M	68.6 M	71.2 M	73.8 M	3.7%
Cancer Care					
Cancer Patient Visits (patients may have multiple visits)	547,972	561,625	560,340	578,005	3.2%
Unique Cancer Patients	48,409	50,103	51,105	52,288	2.3%
Addiction & Mental Health					
Mental Health Hospital Discharges (acute care)	19,278	19,955	21,008	21,429	2.0%
Community Treatment Orders (CTO) Issued	204	271	359	439	22.3%
Addiction Residential Treatment & Detoxification Admissions	9,837	10,059	9,978	11,123	11.5%

BED NUMBERS

Since April 1, 2014, AHS has opened 881 continuing care spaces plus 34 restorative care spaces located in acute care for a total of 915 community-based spaces. Since 2010, AHS has opened 4,284 community-based spaces.

AHS is committed to provide more community-based options for Albertans including long-term care, supportive living, palliative care, home care and restorative care. As community-based capacity becomes available, the system will be better able to open needed beds in both our acute care and emergency care system.

Pediatric cardiologist Dr. Simon Urschel shows three-year-old Abigail Fraser a model of the human heart. Abigail was born with a condition that needed a three-stage surgery, but the first stage was not a success and a heart transplant became the only option. Unfortunately, her body had developed antibodies that meant she would probably reject a donor organ. Doctors developed an anti-rejection therapy. Abigail received a new heart and is doing well.

Number Of Beds/Spaces as of:	March 31, 2014	March 31, 2015	Difference	% Change
Acute & Sub-acute Care				
Acute Care	8,311	8,471	160	1.9%
Sub-acute in Auxiliary Hospital	507	507	0	0.0%
Total Acute & Sub-acute Care	**8,818**	**8,978**	**160**	**1.8%**
Continuing Care				
Auxiliary Hospital	5,527	5,521	-6	-0.1%
Nursing Home	8,843	9,002	159	1.8%
Subtotal Long-Term Care	**14,370**	**14,523**	**153**	**1.1%**
Supportive Living Level 3	1,565	1,544	-21	-1.3%
Supportive Living Level 4	4,889	5,342	453	9.3%
Supportive Living Level 4 - Dementia	2,043	2,333	290	14.2%
Subtotal Supportive Living	**8,497**	**9,219**	**722**	**8.5%**
Subtotal Long-Term Care & Supportive Living	**22,867**	**23,742**	**875**	**3.8%**
Community Palliative and Hospice (outside a hospital)	202	208	6	3.0%
Total Continuing Care	**23,069**	**23,950**	**881**	**3.8%**
Addiction & Mental Health				
Psychiatric (standalone facilities)	967	955	-12	-1.2%
Addiction Treatment	855	883	28	3.3%
Community Mental Health	579	601	22	3.8%
Total Addiction & Mental Health	**2,401**	**2,439**	**38**	**1.6%**
Alberta Total	34,288	35,367	1,079	3.1%

GOVERNANCE

The current governing body of AHS is the Official Administrator. In accordance with Section 11 of the *Regional Health Authorities Act*, the Official Administrator has the responsibility for the governance of AHS while working in partnership with Alberta Health to ensure all Albertans have access to high-quality health services across the province.

The Official Administrator is accountable to the Minister of Health. Dr. Carl Amrhein became the Official Administrator of AHS on November 17, 2014, following Ms. Janet Davidson and Dr. John Cowell, who both held the role at different points throughout 2014-15.

To support the role of the Official Administrator, the governance advisory committees specified below have been established to aid in governing AHS and overseeing the management of AHS' business and affairs. The Official Administrator is a member of each advisory committee and the President & Chief Executive Officer is a non-voting *ex officio* member of each advisory committee.

- Audit & Risk Committee (ARC)
- Finance Committee (FC)
- Quality and Safety Advisory Committee (QSAC)
- Human Resources Advisory Committee (HRAC)

During 2014-15, the Audit and Finance Advisory Committee was divided into the Audit & Risk Committee and the Finance Committee. The Audit & Risk Committee has responsibility to assist in fulfilling oversight responsibilities of the Official Administrator with respect to management and compliance, external financial reporting, internal controls over financial reporting, internal audit and the external audit. The Finance Committee has responsibility to assist in fulfilling the financial oversight responsibilities of the Official Administrator and in overseeing management's administration of AHS on finance related items.

The purpose and scope of each committee is in accordance with good governance practices and is consistent with the governing legislation of AHS.

Below is a list of the current advisory committee members.

Member	Board Advisory Committee
Barbara Burton	HRAC (Chair)
Dr. Tom Feasby	QSAC
Martin Harvey	HRAC
Don Sieben	ARC (Chair), FC (Chair), QSAC, HRAC
Douglas Tupper	QSAC (Chair), ARC, FC, HRAC
Gord Winkel	QSAC

ORGANIZATIONAL STRUCTURE

AHS is responsible for delivering health services to the over four million people living in Alberta.

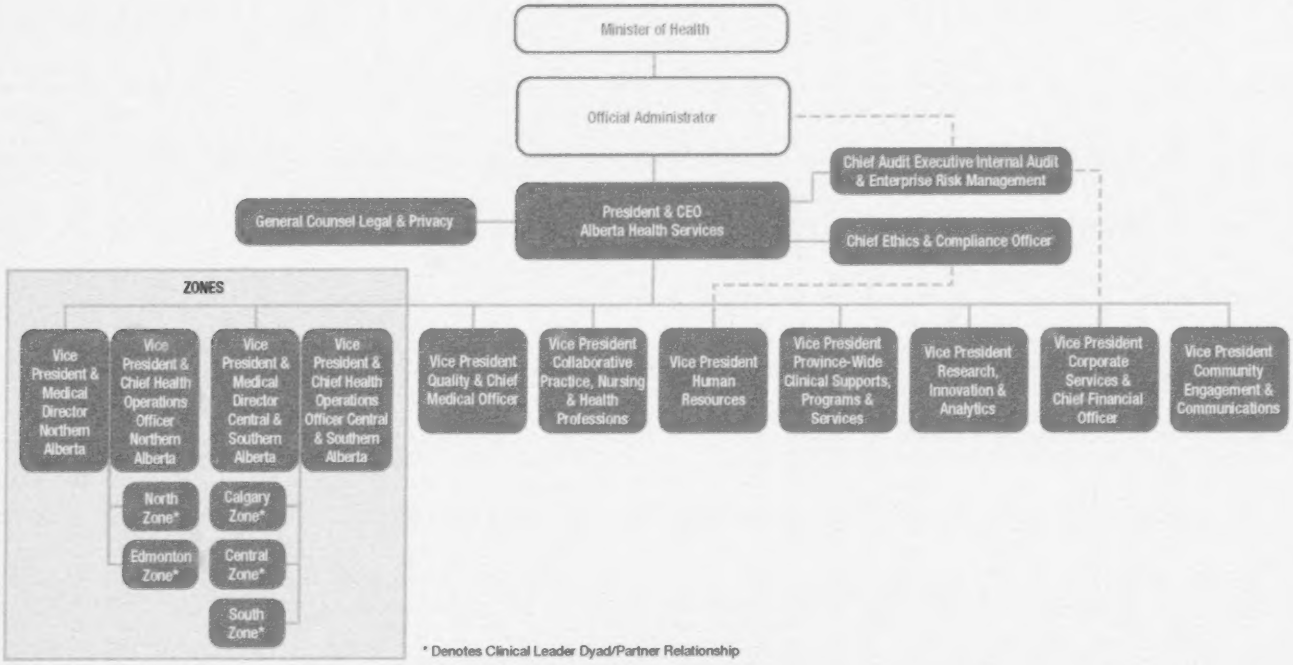
On May 26, 2014, Vickie Kaminski became President and Chief Executive Officer of AHS.

She leads a staff of more than 108,000 caring and dedicated individuals who make up the AHS workforce. In this role, she is leading health services through transformational change, shaping the future for AHS to allow achievement of the goals of access, quality and sustainability.

With leaders and staff in the organization, AHS will build a culture that:

- Exemplifies our values of respect, accountability, transparency, engagement, safety, learning and performance.
- Takes a provincial perspective on issues.
- Ensures good ideas developed in one part of the province are shared across the province.

Our organizational structure is arranged under the following leadership positions, reporting directly to the President and Chief Executive Officer:


Minister of Health
Official Administrator
Chief Audit Executive Internal Audit & Enterprise Risk Management
General Counsel Legal & Privacy
President & CEO Alberta Health Services
Chief Ethics & Compliance Officer
ZONES
Vice President & Medical Director Northern Alberta
Vice President & Chief Health Operations Officer Northern Alberta
Vice President & Medical Director Central & Southern Alberta
Vice President & Chief Health Operations Officer Central & Southern Alberta
North Zone*
Edmonton Zone*
Calgary Zone*
Central Zone*
South Zone*
Vice President Quality & Chief Medical Officer
Vice President Collaborative Practice, Nursing & Health Professions
Vice President Human Resources
Vice President Province-Wide Clinical Supports, Programs & Services
Vice President Research, Innovation & Analytics
Vice President Corporate Services & Chief Financial Officer
Vice President Community Engagement & Communications

* Denotes Clinical Leader Dyad/Partner Relationship

COUNCILS

Health Advisory Councils

The Health Advisory Councils (HACs) support AHS in achieving its strategies by engaging members of the public in communities throughout Alberta, and providing advice and feedback from a local perspective on what is working well in the health care system and where there are areas in need of improvement. Each of the 12 HACs was established in 2009-10 and represents a different geographical area within the province.

AHS has worked with the 12 HACs and two Provincial Advisory Councils to establish a Council of Chairs. The Council provides advice and feedback to the Official Administrator.

The Provincial Advisory Council on Cancer is an advisory body to AHS and provides evidence-based suggestions on cancer care for Albertans. This Council is comprised of 15 volunteers, including members who are experts in their cancer-related field as well as public members who have been touched by cancer, diagnosed with cancer or are cancer survivors.

The Provincial Advisory Council on Addiction & Mental Health is an advisory body to AHS to enhance the delivery of addiction and mental health services. This Council is composed of 15 volunteer members (three members per AHS zone). They may be AHS service providers or members of the public who have been touched by addiction and/or mental health, either as a patient, or through the experience of a family member or close associate.

Health Advisory Council	Geographical Areas	HAC Chair
1. True North	La Crete, High Level & Area	Michael Osborn
2. Peace Health	Peace River, Grande Prairie & Area	Lucille Partington
3. Lesser Slave Lake	Slave Lake, High Prairie & Area	Ken Matthews
4. Wood Buffalo	Fort McMurray & Area	Iris Kirschner
5. Lakeland Communities	Lac LaBiche, Redwater, Cold Lake & Area	James Lamouche
6. Tamarack	Hinton, Edson, Whitecourt & Area	Ruth Martin-Williams
7. Greater Edmonton	Edmonton & Area	Brenda Chomey
8. Yellowhead East	Camrose, Lloydminster & Area	Pat Carey
9. David Thompson	Red Deer & Area	Gerald Ingeveld
10. Prairie Mountain	Calgary & Area	Larry Albrecht
11. Palliser Triangle	Medicine Hat & Area	Dr. Kenneth Sauer
12. Oldman River	Lethbridge & Area	Dr. Barbara Lacey

Alberta Clinician Council

The Alberta Clinician Council (ACC) is an organization-wide forum comprised of approximately 45 front-line clinicians from a variety of disciplines and zones across the province. Applying their collective knowledge, experience and expertise, the council advises senior leadership on issues and opportunities to improve quality, access and patient safety across the province.

The Council is accountable to both the AHS President and Chief Executive Officer and front-line clinicians. Four meetings were held in the 2014-15 year with a total of 14 consultations on topics such as the Patient First Strategy, the People Strategy, Strategic Clinical Networks, the AHS Information Management/Information Technology (IM/IT) Strategy, and the AHS Research and Innovation Plan.

Patient and Family Advisory Group

The Patient and Family Advisory Group has been an important avenue for bringing the patient voice into AHS since December 2010. The group partners with senior leaders to review policy and strategies and share insights from the patients' perspective for the planning and delivery of health care services. In 2014-15, 1,458 hours of service were volunteered and the advisors participated in 27 consults on topics such as the IM/IT Strategy, the Patient First Strategy, the People Strategy, CoACT, First Available Bed Policy, Preferential Access and other priority initiatives.

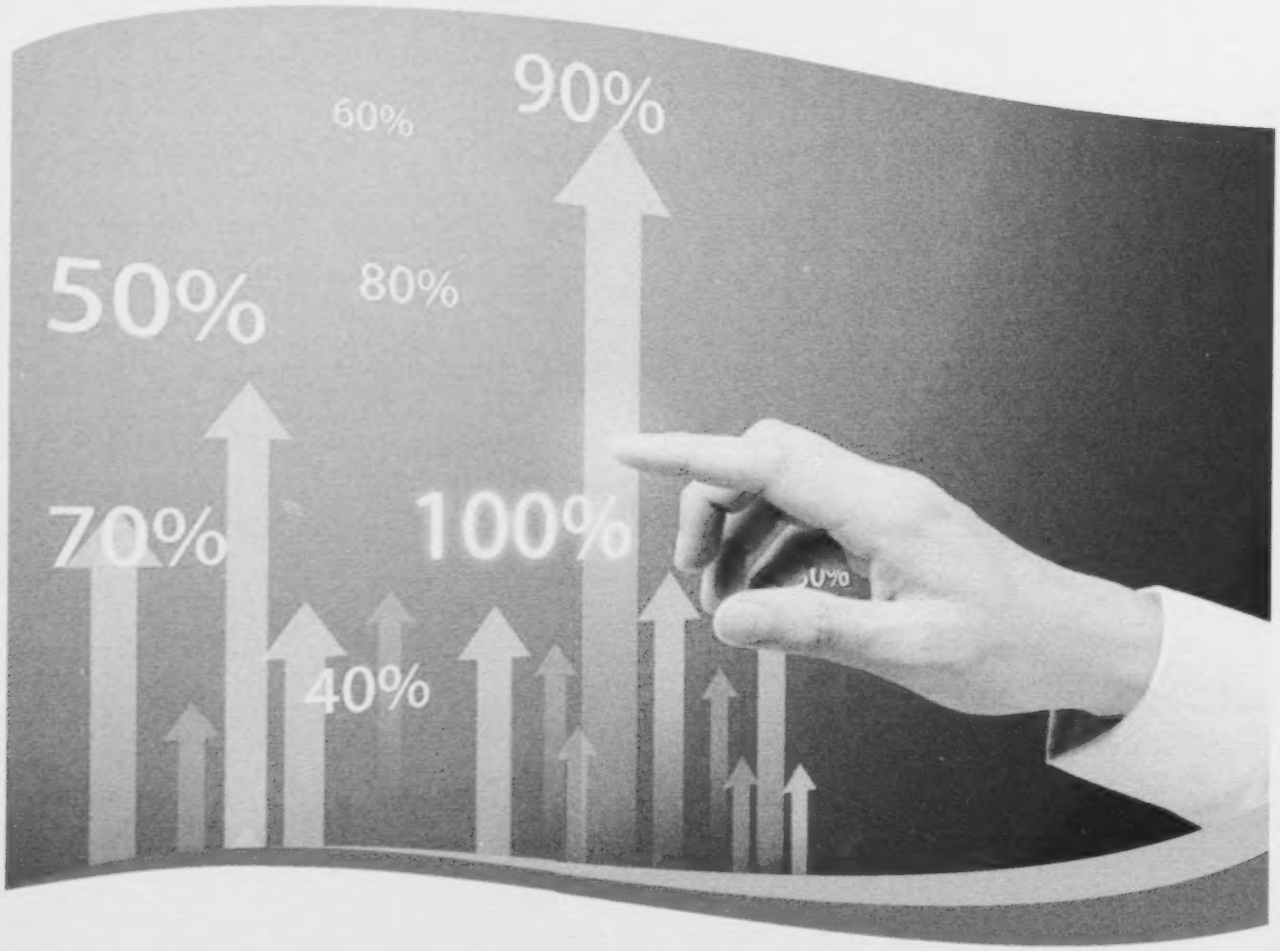
Patient and Family Advisors give their time to numerous committees and projects in AHS, including co-chairing the Patient First Steering Committee and membership on other committees, such as End of Life Palliative Care Steering, People Strategy Steering, Zone Quality, Zone Patient and Family Centered Care, and Policy and Forms Steering Councils as well as TeamCARE. They also share their stories and provide education to numerous groups both inside and outside the organization.

In the summer of 2014, Advisors presented with AHS staff at the International Patient- and Family-Centred Care Conference in Vancouver. This group was also part of the first Alberta Patient Advisor Conference held October 2014 in Edmonton. Recommendations from that conference are being used across the organization.

The Wisdom Council provides guidance and recommendations to ensure AHS develops and implements culturally appropriate and innovative health service delivery for Aboriginal Peoples. It is comprised of aboriginal people who volunteer their time on the council. Their backgrounds are wide-ranging including traditional knowledge holders (ceremonial leaders), contemporary trained physicians, nursing professionals and health consultants, all equally important when discussing challenges to inform AHS on aboriginal health and well-being.

Provincial AHS strategies such as the Patient First Strategy and the Continuing Care Resolution Team have garnered support and input from the council as AHS commits to improving the health and wellness for First Nations, Métis and Inuit people and communities within Alberta. The Wisdom Council continues to support the overall strategic directions of AHS; more specifically, the Aboriginal Health Program.

PERFORMANCE



PERFORMANCE MEASURES

In collaboration with Alberta Health, AHS established 16 performance measures in January 2014 to help us continue to build and strengthen our health care system. We will continue to monitor these and other measures to support the health and well-being of all Albertans and to support front-line health care providers.

We have streamlined performance measures to ensure they represent the broad spectrum of health care, including targets for community-based care and patient outcomes. We've added measures that align with national standards where possible, so Albertans can easily compare the performance of our health system with other health systems across Canada. Having measures aligned with national and Western Canadian benchmarks improves the transparency of our reporting by putting our accomplishments into a broader context. Also, these measures are updated quarterly and posted on the AHS Data, Statistics and Reporting webpage.

Our performance measures are organized by the Alberta Quality Matrix for Health, which describes six dimensions of quality.

Targets have been created for the new 16 performance measures for 2014-15 and 2015-16. The performance targets for 2014-15 and 2015-16 are challenging but achievable. These performance targets will help us measure our progress and improve the health system.

The chart on the following page demonstrates trending of AHS' system performance measures. Seven out of 16 measures have achieved 2014-15 targets. Six measures reflect the third quarter year-to-date data (April 1, 2014 to December 31, 2014); once 2014-15 data is available for these measures, the chart below will be refreshed and published. Two measures are only reported annually (i.e., satisfaction with long-term care and early detection of cancer).

Acceptability	Accessibility	Appropriateness	Effectiveness	Efficiency	Safety
Health services are respectful and responsive to user needs, preferences and expectations.	Health services are obtained in the most suitable setting in a reasonable time and distance.	Health services are relevant to user needs and are based on accepted or evidence-based practice.	Health services are provided based on scientific knowledge to achieve desired outcomes.	Resources are optimally used in achieving desired outcomes.	Mitigate risks to avoid unintended or harmful results.

The trend column indicates comparison of the most recent data over the earliest data available for each measure. A check (✔) indicates the 2014-15 was achieved; an upward arrow (↑) indicates improvement; a horizontal arrow (→) indicates stability and a downward arrow (↓) indicates areas that require additional focus.

Performance Measures	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2014-15 Target	Trend
Acceptability									
Satisfaction with Hospital Care: *The percentage of adult patients who rated their overall care in hospital as 8, 9 or 10, where zero is the lowest level of satisfaction possible and 10 is the best.*	Not Available		81.4%	83.6%	81.3%	81.5%	81.7% (Q3 YTD)	82%	✔
Satisfaction with Long-Term Care: *The percentage of families of long-term care residents who rated the overall care as 8, 9 or 10, where zero is the lowest level of satisfaction possible and 10 is the best.*	Long-Term Care - 71% (2007-2008) This measure is updated every two - three years.		73%	HQCA Supportive Living 2013-14: Residents rated their care at an average of 7.8 out of 10.				78% (2015-16)	↑
Safety									
Hospital Acquired Infections: *The number of Clostridium difficile infections (C-diff) acquired in hospital every 10,000 days of care. A rate of 4 means approximately 100 patients per month acquires C-diff infections in Alberta.*	Not Available			4.2	4.1	4.4	3.7 (Q3 YTD)	4.0	✔
Hand Hygiene: *The percentage of times health care workers clean their hands during the course of patient care.*	Not Available			49.6%	59.3%	66.4%	73.4%	71%	✔
Hospital Mortality: *The actual number of deaths compared to the expected number of deaths in hospital. Values less than 100 mean fewer than expected deaths. In Alberta, a rate of 84 means 850 fewer deaths in hospital than expected each year.*	103.2	98.3	92.4	87.9	84.0	84.2	82.3	84.0	✔
Accessibility									
Emergency Department (ED) Wait to see a Physician: *The average patient's length of time in ED before being seen by a physician at the 17 busiest EDs.*	Not Available			1.4 hours	1.3 hours	1.3 hours	1.4 hours	1.3 hours	↓
Emergency Department Length of Stay for Admitted Patients (hours): *The average patient's length of time in the ED before being admitted to a hospital bed at the 16 busiest ED.*	10.8 hours	10.3 hours	9.8 hours	8.8 hours	8.7 hours	8.6 hours	9.9 hours	8.5 hours	↓
Emergency Department Length of Stay for Discharged Patients (hours): *The average patient's length of time in the ED before being discharged at the 17 busiest ED.*	3.2 hours	3.1 hours	3.1 hours	3.1 hours	3.1 hours	3.0 hours	3.2 hours	3.0 hours	↓
Access to Radiation Therapy: *The length of time or less that 9 out of 10 patients wait to receive radiation therapy (in weeks).*	Not Available	5.3 weeks	3.6 weeks	3.1 weeks	3.0 weeks	3.0 weeks	3.1 weeks	2.8 weeks	↓

Performance Measures	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2014-15 Target	Trend
Appropriateness									
Continuing Care Placement: *The percentage of people placed into continuing care within 30 days of being referred.*	Not Available		55%	64%	67%	69%	60%	68%	↓
Efficiency									
Acute (Actual) Length of Stay Compared to Expected Stay: *The actual length of stay in hospital compared to the expected length of stay in hospital. Every .01 drop in this ratio means we can treat over 3,200 more patients in hospital every year.*	1.04	1.02	1.01	1.00	0.98	0.97	0.96	0.97	✔
Effectiveness									
Early Detection of Cancer: *The percentage of patients with breast, cervical and colorectal cancers who are diagnosed at early stages.*	64.6% (2008)	65.4% (2009)	66.6% (2010)	66.1% (2011)	66.8% (2012)	Not Available		67%	↑
Mental Health Readmissions: *The percentage of mental health patients with unplanned readmission to hospital within 30 days of leaving hospital.*	9.4%	9.2%	9.5%	9.4%	9.6%	9.4%	9.3% (Q3 YTD)	9.6%	✔
Surgery Readmissions: *The percentage of surgical patients with unplanned readmission to hospital within 30 days of leaving hospital.*	5.8%	5.9%	6.2%	6.6%	6.6%	6.7%	6.5% (Q3 YTD)	6.4%	↑
Stroke Mortality: *The percentage of patients dying in hospital within 30 days of being admitted for a stroke.*	12.6%	11.7%	13.2%	13.5%	15.0%	14.1%	14.0% (Q3 YTD)	14.3%	✔
Heart Attack Mortality: *The percentage of patients dying in hospital within 30 days of being admitted for a heart attack.*	6.5%	6.3%	6.2%	6.5%	5.9%	7.2%	6.1% (Q3 YTD)	5.9%	↑

The performance measures related to access (emergency department, cancer care and continuing care) demonstrated a decline in performance in 2014-15. Access to services is a major issue in Alberta. By improving access to a few key areas, we will be able to improve patient flow throughout the system, provide more appropriate care to meet patient needs, decrease wait times and deliver care in a more cost effective manner.

A key concern to Albertans is a lack of access to family physicians (primary care). Provision of primary care services is the foundation for an effective health care system. This is an area we are working to strengthen in Alberta to meet current and future needs. Investing in this area will improve health outcomes and reduce demand on hospitals.

Another major concern related to access is seniors care. This issue will continue to grow with the aging of our population and needs a focused multiple-strategy approach. We will offer seniors and persons with disabilities more options for quality accommodations that suit their lifestyles and service needs. By improving choice and availability of services, more capacity will be opened for acute care patients inappropriately waiting for continuing care (home care, supportive living and long-term care).

MONITORING MEASURES

There are a number of measures that AHS monitors internally to help inform us about other areas of the health system. These monitoring measures do not have targets, and some of these measures do not have benchmarks across the country for comparison. However, these measures are familiar and of interest to Albertans. These measures are updated quarterly and posted on the AHS Data, Statistics and Reporting webpage.

The measures presented below track our performance using a broad range of indicators that span the continuum of care. They include population and public health, primary care, continuing care, and access to cancer care, emergency department and surgery.

The following measures contribute to balanced performance monitoring and reporting that have been tracked over many years. AHS continues to collect and monitor these measures to help support priority setting and local decision-making. These measures are tactical as they inform the performance of an operational area; or reflect the performance of key drivers of a strategic measure.

Life Expectancy	2008	2009	2010	2011	2012	2013	2014	Trend
Life Expectancy: The number of years a person would be expected to live, starting at birth, on the basis of mortality statistics. Both sexes combined.								
Provincial	**80.5**	**81.0**	**81.4**	**81.6**	**81.7**	**81.7**	**81.8**	↑
First Nations	69.8	71.2	72.1	70.8	72.2	72.5	71.7	↓
Non-First Nations	81.0	81.3	81.8	82.0	82.0	82.1	82.8	↑
Females	n/a	n/a	83.7	83.7	83.9	83.8	83.9	↑
Males	n/a	n/a	79.1	79.4	79.5	79.6	79.7	↑
Potential Years of Life Lost	2008	2009	2010	2011	2012	2013	2014	Trend
Potential Years of Life Lost per 1,000 Population: The total number of years not lived by an individual who died before their 75th birthday.								
Total Population	**49.0**	**46.6**	**44.6**	**43.4**	**43.1**	**42.8**	**44.5**	↓
Females	37.4	37.1	34.2	33.6	32.9	33.9	34.8	↓
Males	60.0	55.6	54.5	52.8	52.8	51.5	53.7	↓
Cancer Screening Participation Rates	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	Trend
Breast	55.9%	57.3%	54.8%	58.4%	58.0%	56.8%	n/a	↓
Colorectal	35.5% (2008)	43.0% (2009)	57.0% (2011)	53.0% (2012)	n/a	n/a	n/a	↓
Cervical	70.7% (2007-09)	67.9% (2008-10)	65.0% (2009-11)	63.5% (2010-12)	64.2% (2011-13)	62.7% (2012-14)	n/a	↓

Influenza Immunization	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	Trend
Rates of seasonal influenza immunization by age group							
• Children six months to 23 months	16.0%	27.0%	29.9%	30.2%	35.7%	35.6%	→
• Adults 65 years and older	55.6%	58.9%	60.8%	60.0%	63.6%	60.5%	↓
AHS Staff Influenza Immunization	pending	pending	pending	pending	60%	64%	↑
Childhood Immunization	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**Trend**
Rates of childhood immunization by two years of age in all service zones:							
• diphtheria/ tetanus/ acellular pertussis, polio, Hib	77.0%	73.7%	74.6%	74.6%	74.3%	75.7%	↑
• measles/ mumps/ rubella	87.1%	86.1%	85.8%	85.7%	85.7%	88.3%	↑
Primary Care	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**Trend**
Albertans Enrolled in a Primary Care Network	64% (April 2010)	72% (April 2011)	75% (April 2012)	76% (April 2013)	78% (April 2014)	79% (Oct. 2014)	↑
Ambulatory Care Sensitive Conditions: Rate of hospital admissions for health conditions that may be managed by appropriate primary health care.	298	293	291	293	291	299	↓
Family Practice Sensitive Conditions: Percent of emergency department or urgent care visits for health conditions that may be appropriately managed at a family physician's office.	27.4%	27.5%	26.4%	26.0%	25.1%	24.3%	↑
Health Information	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**Trend**
Health Link Alberta: Percentage of calls to Health Link that are answered within two minutes.	66%	78%	81%	78%	79%	77%	↓
Children's Mental Health Services	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**Trend**
Percent of children aged 0 to 17 years receiving scheduled mental health treatment within 30 days.	n/a	75%	76%	80%	81%	82%	↑
Emergency Department	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**Trend**
Percentage of patients treated and discharged from the Emergency Department within 4 hours							
Busiest 17 sites	63%	64%	65%	65%	66%	64%	↓
All sites	80%	80%	80%	80%	80%	79%	↓
Percentage of patients treated and admitted to hospital from the Emergency Department within 8 hours							
Busiest 16 sites	38%	41%	45%	45%	46%	39%	↓
All sites	49%	53%	55%	55%	54%	48%	↓

Cancer Wait Time In Weeks (90th Percentile)	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	Trend
Radiation Oncology Access: Referral to first consult (from referral to the time of their first appointment with a radiation oncologist)	7.4	6.0	5.4	4.9	4.9	4.9	→
Medical Oncology Access: Referral to first consult (from referral to the time of their first appointment with a medical oncologist)	n/a	6.0	5.1	4.9	5.6	5.6	→
Surgery Wait Time (90th Percentile)	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**Trend**
CABG Urgency III – Scheduled	31.0	24.0	28.8	25.9	21.5	23.7	↓
Cataract Surgery	41.0	46.9	37.3	31.6	32.4	33.4	↓
Hip Replacement Surgery	36.4	38.9	39.8	36.3	36.7	36.3	↑
Knee Replacement Surgery	49.1	48.9	48.0	40.9	41.9	44.9	↓
Hip Fracture Repair: % within 48 hours	82.8%	85.7%	84.4%	84.9%	88.4%	86.2%	↓
Continuing Care	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**Trend**
Total Number of People Placed into Continuing Care	n/a	7,038	7,700	7,761	7,694	7,810	↑
• from **acute / sub-acute** hospital bed into continuing care	n/a	4,951	5,355	5,561	5,522	5,548	↑
• from **community (at home)** into continuing care	n/a	2,087	2,345	2,200	2,172	2,262	↑
Average wait time in acute / sub-acute care hospital bed for continuing care placement (in days)	n/a	54	41	34	31	42	↓
Total Number Waiting For Continuing Care Placement:	1,746	1,586	1,469	1,154	1,193	1,544	↓
• waiting in acute / sub-acute hospital bed	707	471	467	453	512	690	↓
• waiting in community (at home)	1,039	1,115	1,002	701	681	854	↓
Number of unique home care clients	n/a	100,309	104,516	109,184	112,062	114,990	↑

FINANCIAL STATEMENTS

FINANCIAL STATEMENT DISCUSSION AND ANALYSIS For the year ended March 31, 2015

(in millions of dollars)

Purpose

This Financial Statement Discussion and Analysis (FSD&A) is provided to enable readers to assess the results of Alberta Health Services' (AHS) operations and financial condition for the year ended March 31, 2015 compared to budget and to the preceding year. In particular, the FSD&A reports to stakeholders on how financial resources are being managed to provide a patient-focused, quality health system that is accessible and sustainable for all Albertans.

This FSD&A has been prepared by management and should be read in conjunction with the March 31, 2015 audited consolidated financial statements, notes and schedules. The consolidated financial statements are prepared in accordance with Canadian Public Sector Accounting Standards (PSAS) and Financial Directives issued by Alberta Health (AH). All amounts are in millions of dollars unless otherwise specified.

AHS financial statements are prepared on a consolidated basis and include the following:

- 3 wholly owned subsidiaries: Calgary Laboratory Services Ltd., Capital Care Group Inc., and Carewest;
- 30 controlled foundations;
- Provincial Health Authorities of Alberta Liability and Property Insurance Plan (LPIP) and the Queen Elizabeth II Hospital Child Care Centre; and
- 50 per cent (%) interest in the 42 Primary Care Networks (PCNs), 50% interest in the Northern Alberta Clinical Trials Centre (NACTRC) joint venture, and 30% in the HUTV Limited Partnership (HUTV).

Additional information about AHS including financial reports from prior periods is available on the AHS website at www.albertahealthservices.ca.

Overview of 2014-15

The following table summarizes the Consolidated Statement of Operations:

STATEMENT OF OPERATIONS	BUDGET 2015	ACTUAL 2015	VARIANCE 2015	ACTUAL 2014	INCREASE (DECREASE)
Revenue	$ 13,568	$ 13,797	$ 229	$ 13,189	$ 608
Expenses	13,568	13,800	(232)	13,033	767
Operating surplus (deficit)	**$ -**	**$ (3)**	**$ (3)**	**$ 156**	**$ (159)**

In 2014-15, key strategic areas included:

- Ensuring quality of care in our communities;
- Partnering for better health outcomes; and
- Achieving health system sustainability.

In 2014-15, the provision of health-care services for Albertans cost AHS an average of $38 per day, based on annual expenditures of $13,800.

AHS continues to face increasing demand for health services due to Alberta having the fastest-growing population in Canada, the population living longer and having diverse community needs, and increased costs for health services.

AHS' total revenue increased by $608 or 4.6% from 2013-14 to 2014-15. The change is a result of funding from AH which increased by $482 or 4.1% and other revenue which increased by $126 or 9.3%. Total expenses increased by $767 or 5.9% from 2013-14 to 2014-15. The 5.9% increase in expenses in 2014-15 is consistent with the average growth rate for expenses of 6.3% experienced by AHS each year since 2008. As the increase in funding from AH was less than the increase in total expenses incurred in the year, AHS managed the shortfall through the diversification of income source opportunities, primarily related to investment and other income, which resulted in balancing revenues and expenses in the year.

During the fourth quarter, AHS implemented additional measures to further increase cost containment efforts as a result of the changing financial environment. As these measures were implemented near the end of the fiscal year they did not significantly impact the 2014-15 results.

Operating Results:

AHS finished the year ended March 31, 2015 effectively balanced compared to its approved balanced budget. A positive revenue variance of $229 is offset by a negative expense variance of $232.

As the 2014-15 budget was prepared, collective agreements with the United Nurses of Alberta (UNA), the Alberta Union of Provincial Employees (General Support Services) (AUPE GSS) and the Health Sciences Association of Alberta (HSAA) were all under negotiation. AHS included a 0% budget increase for these agreements consistent with the Alberta government's direction on public sector salaries. During 2014-15, multiple collective agreements were settled and ratified resulting in additional compensation costs to AHS in the year. As these costs were unbudgeted, they have resulted in the most significant expense variance in salaries and benefits, and across most expense lines by function. This expense variance was offset by additional funding received from AH during 2014-15, which is reflected in base operating transfers.

The $229 positive revenue variance is primarily due to unbudgeted supplemental one-time funding from AH, higher amortization costs than anticipated resulting in the recognition of expended deferred capital revenue, higher than budgeted investment income associated with strong growth in the Canadian and US equity markets and higher fixed income portfolio balances, and unbudgeted miscellaneous income. The overall positive variance was partially offset by lower revenue recognized from AH transfers due to various programs not yet operating at capacity while operations are ramping up at the South Health Campus, delayed implementation of various initiatives, lower volume of specialized high cost and rare disease drugs provided at no cost to patients, and lower revenue recognized due to activity and vacancies in physician services programs.

The $232 negative expense variance is primarily due to unbudgeted costs related to collective agreements, increased activity levels across the province, including demand for acute care, and home care, higher amortization costs than anticipated, compensation rate variances, and overtime. Offsetting the overall negative variance are net vacancies related to recruiting physician and staff positions, timing delays in the implementation of new and ongoing initiatives, and the achievement of cost control strategies.

Accumulated Surplus:

The AHS accumulated surplus for the year ended March 31, 2015 is $1,231 compared to the prior year of $1,234. Accumulated surplus consists of three main components: unrestricted net assets, reserves for future purposes, and net assets invested in tangible capital assets.

The unrestricted net assets at March 31, 2015 of $272 do not have any restrictions attached to their future use and may be used at AHS' discretion for operating purposes or capital purposes, which may be formally appropriated as a reserve. Future potential uses of the unrestricted net asset balance include major information technology investments such as clinical information systems and further investment in deferred capital maintenance.

	ACTUAL 2015	ACTUAL 2014	INCREASE (DECREASE)
Accumulated surplus	$ 1,231	$ 1,234	$ (3)
Less: Net assets invested in tangible capital assets	(804)	(881)	77
Less: Reserves for future purposes	(155)	(87)	(68)
Unrestricted net assets	**$ 272**	**$ 266**	**$ 6**

Net assets invested in tangible capital assets and reserves for future purposes have been restricted internally by AHS, as approved by the Official Administrator, and are therefore not available for any other purpose.

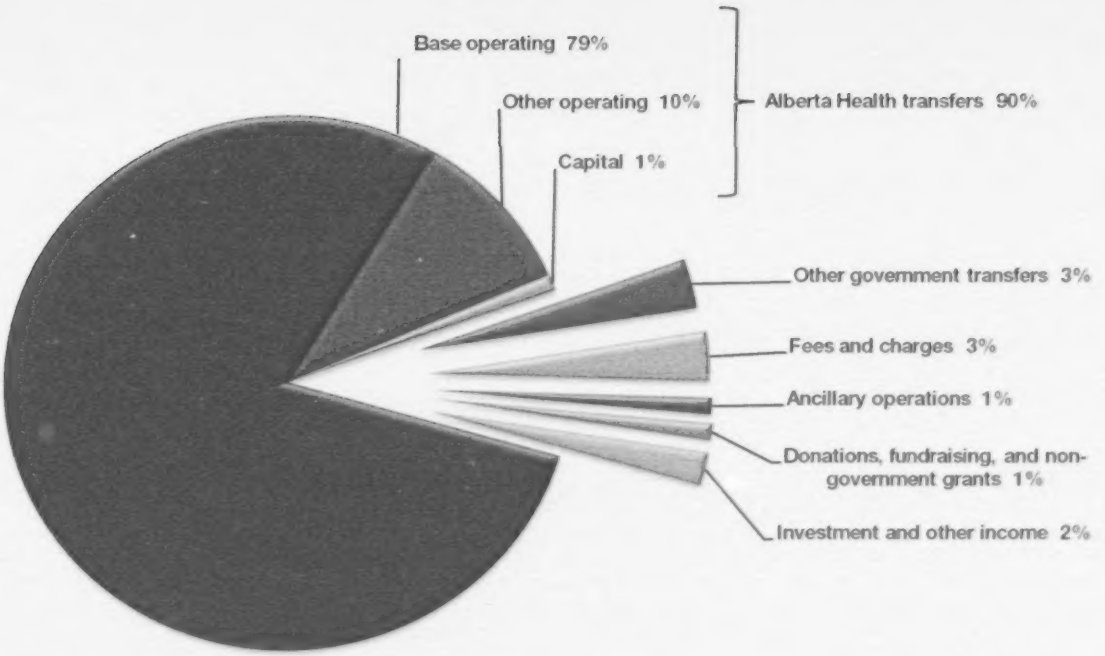
- The net assets invested in tangible capital assets at March 31, 2015 of $804 represents the net book value of tangible capital assets that have previously been purchased with AHS unrestricted net assets.

- The reserves for future purposes at March 31, 2015 of $155 have been set aside for future operating and capital purposes related to parkade infrastructure, cancer research, special local initiatives, and retail food services infrastructure. AHS also established three new reserves in the year related to the Provincial Clinical Information Systems Initiative, insurance equity requirements, and future capital purposes.

AHS' annual expenditures of $13,800 equates to approximately $38 per day, hence the unrestricted net assets of $272 represents approximately 7.2 days, or 2.0% of total annual expenses.

Statement of Operations

REVENUE



Total 2014-15 revenues increased by $608 or 4.6% from 2013-14 and were higher than budgeted amounts by $229. The overall increase in revenue from 2013-14 was primarily due to increased base operating transfers from AH, which is AHS' primary source of funding. The AH funding coverage is 89% (2014 – 91%), representing the percent of total expenses funded by AH in 2014-15.

REVENUE	BUDGET 2015	ACTUAL 2015	VARIANCE 2015		ACTUAL 2014	INCREASE (DECREASE)	
Alberta Health transfers	$ 12,274	$ 12,322	$ 48	0.4%	$ 11,840	$ 482	4.1%
Other government transfers	402	421	19	4.7%	387	34	8.8%
Fees and charges	447	446	(1)	(0.2%)	432	14	3.2%
Ancillary operations	127	133	6	4.7%	126	7	5.6%
Donations, fundraising and non-government grants	143	167	24	16.8%	155	12	7.7%
Investment and other income	175	308	133	76.0%	249	59	23.7%
Total revenue	**$ 13,568**	**$ 13,797**	**$ 229**	**1.7%**	**$ 13,189**	**$ 608**	**4.6%**

Significant variances and changes are explained as follows:

- **Alberta Health transfers** are comprised of all AH transfers – unrestricted, restricted operating and capital. Unrestricted AH transfers are the main source of operating funding to provide health-care services to the population of Alberta. Restricted operating and capital funding can only be used for specific projects and is recognized when the related expenses are incurred.

Alberta Health Transfers	BUDGET 2015	ACTUAL 2015	VARIANCE 2015		ACTUAL 2014	INCREASE (DECREASE)	
Base operating	$ 10,731	$ 10,851	$ 120	1.1%	$ 10,496	$ 355	3.4%
Other operating	1,459	1,378	(81)	(5.6%)	1,257	121	9.6%
Capital	84	93	9	10.7%	87	6	6.9%
Total AH transfers	**$ 12,274**	**$ 12,322**	**$ 48**	**0.4%**	**$ 11,840**	**$ 482**	**4.1%**

Base operating transfers amounted to $10,851 compared to a budget of $10,731, resulting in a positive variance of $120 or 1.1% due to supplemental base funding for unbudgeted costs associated with collective agreements.

Compared to the prior year, base operating transfers increased by $355 or 3.4% due to supplemental base funding received in 2014-15 for the delivery of health services across Alberta.

Other operating transfers amounted to $1,378 compared to a budget of $1,459, resulting in a negative variance of $81 or 5.6% mainly due to various programs not yet operating at capacity while operations are ramping up at the South Health Campus, delayed implementation of various initiatives primarily under Addiction & Mental Health, Population and Public Health, Seniors, Correctional Health and Cancer Control Alberta, lower volume of specialized high cost and rare disease drugs provided at no cost to patients, higher than anticipated outpatient cancer drug rebates, and vacancies in grant funded physician services programs.

Compared to the prior year, other operating transfers increased by $121 or 9.6% primarily due to increased activity at the South Health Campus, Kaye Edmonton Clinic, and various physician services programs, opening of the Strathcona Community Hospital in May 2014, increase in physician compensation rates, spending ramp up for previously delayed information technology (IT) projects, and fewer IT costs capitalized.

Capital transfers amounted to $93 compared to a budget of $84, resulting in a positive variance of $9 or 10.7% mainly due to higher amortization costs than anticipated resulting in the recognition of expended deferred capital revenue.

Compared to the prior year, capital grants increased by $6 or 6.9% due to incremental revenue associated with tangible capital asset additions partially offset by reductions related to various tangible capital assets that were fully amortized in 2014-15.

- **Other government transfers** are ongoing and one-time transfers for operating and capital purposes from federal, provincial (other than AH), and municipal governments.

Other government transfers amounted to $421 compared to a budget of $402, resulting in a positive variance of $19 or 4.7% mainly due to higher amortization costs than anticipated resulting in the recognition of expended deferred capital revenue, fewer IT costs capitalized, and changes to the timing of major equipment expenditures. The overall positive variance was partially offset by lower activity in infrastructure maintenance and minor equipment projects funded by Alberta Infrastructure (AI).

Compared to the prior year, other government transfers increased by $34 or 8.8% mainly due to expended deferred capital revenue recognized for tangible capital asset additions and fewer IT costs capitalized. The overall increase was partly offset by fewer operating projects implemented for infrastructure maintenance.

- **Fees and charges** revenue consists of patient revenue for health services provided at rates set by the Minister and collected by AHS from individuals, Workers' Compensation Board (WCB), federal and provincial governments, and other parties, such as Alberta Blue Cross and insurance companies.

  Fees and charges revenue amounted to $446 compared to a budget of $447, resulting in a negative variance of $1 or 0.2%.

  Compared to the prior year, fees and charges revenue increased by $14 or 3.2% mainly due to increased activity involving out-of-country patients and services billable to other responsible parties. The overall increase was partially offset by lower activity related to WCB and out-of-province patient billings.

- **Ancillary operations** are the sale of goods and services that are unrelated to the direct provision of health services and include parking, non-patient food services, and rental operations.

  Ancillary operations revenue amounted to $133 compared to a budget of $127, resulting in a positive variance of $6 or 4.7% mainly due to staff parking fee increases, higher than expected demand for visitor parking, and unbudgeted cost recoveries from third parties.

  Compared to the prior year, ancillary operations increased by $7 or 5.6% mainly due to staff and visitor parking fee increases, higher demand for visitor parking, increased revenue from services provided to third parties, retail food services, gift shops and sale of radiopharmaceuticals to third parties.

- **Donations, fundraising and non-government grants** is comprised of revenue that can be unrestricted or restricted for operating or capital purposes. Restricted amounts received are recognized as revenue when the restrictions are met.

  Donations, fundraising and non-government grants revenue amounted to $167 compared to a budget of $143, resulting in a positive variance of $24 or 16.8% mainly due to increased revenue recognized from expended deferred capital revenue as a result of major equipment and building service equipment put into service in the year, and higher than budgeted spending on various research studies and clinical trials.

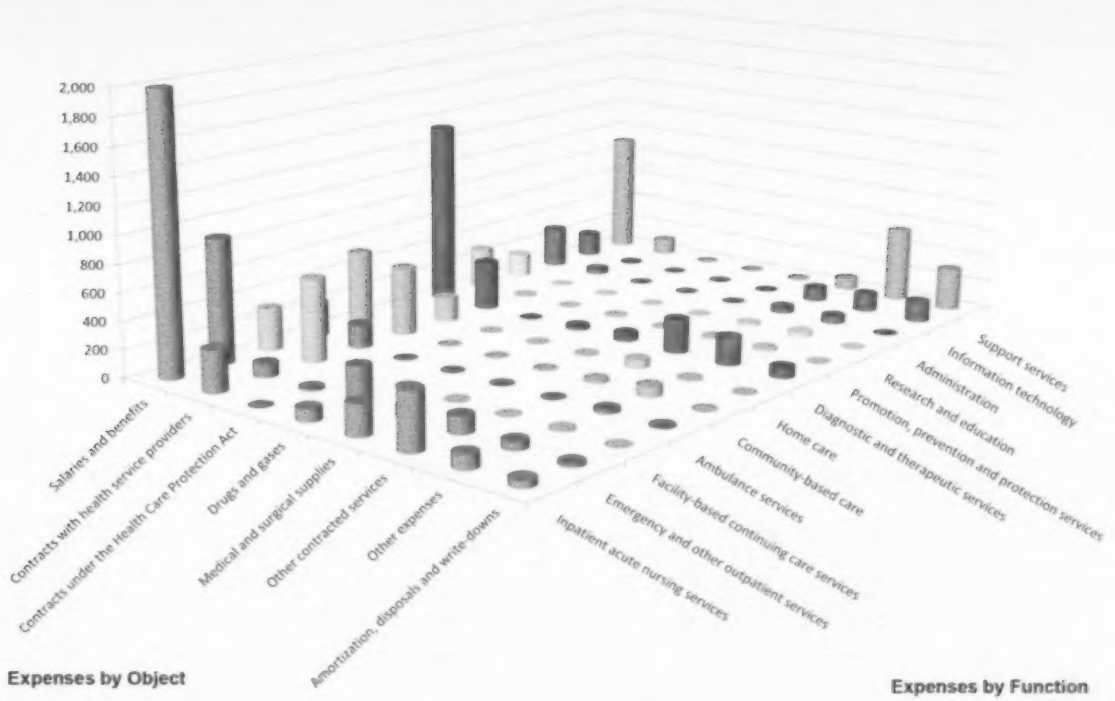
  Compared to the prior year, donations, fundraising and non-government grants increased by $12 or 7.7% mainly due to higher expended deferred capital revenue recognized as a result of tangible capital asset put into service in the year. The overall increase was partly offset by lower revenue recognized from restricted research and education grants, and restricted donations.

- **Investment and other income** is comprised of interest income, dividends, net realized gains and losses on disposal of investments, and recoveries from external sources other than ancillary operations. Included are revenues from third parties, such as drug and medical supply companies and universities (for purposes other than research).

  Investment and other income amounted to $308 compared to a budget of $175, resulting in a positive variance of $133 or 76.0% mainly due to strong growth in the Canadian and US equity markets, which resulted in higher than expected dividends and realized gains, and higher fixed income portfolio balances providing greater interest income. The positive variance is also the result of unbudgeted miscellaneous income such as surplus distribution revenue from the WCB, GST rebate revenue, physician fees assigned to AHS in relation to income guarantee agreements, and drugs received at no cost by the outpatient cancer drugs program.

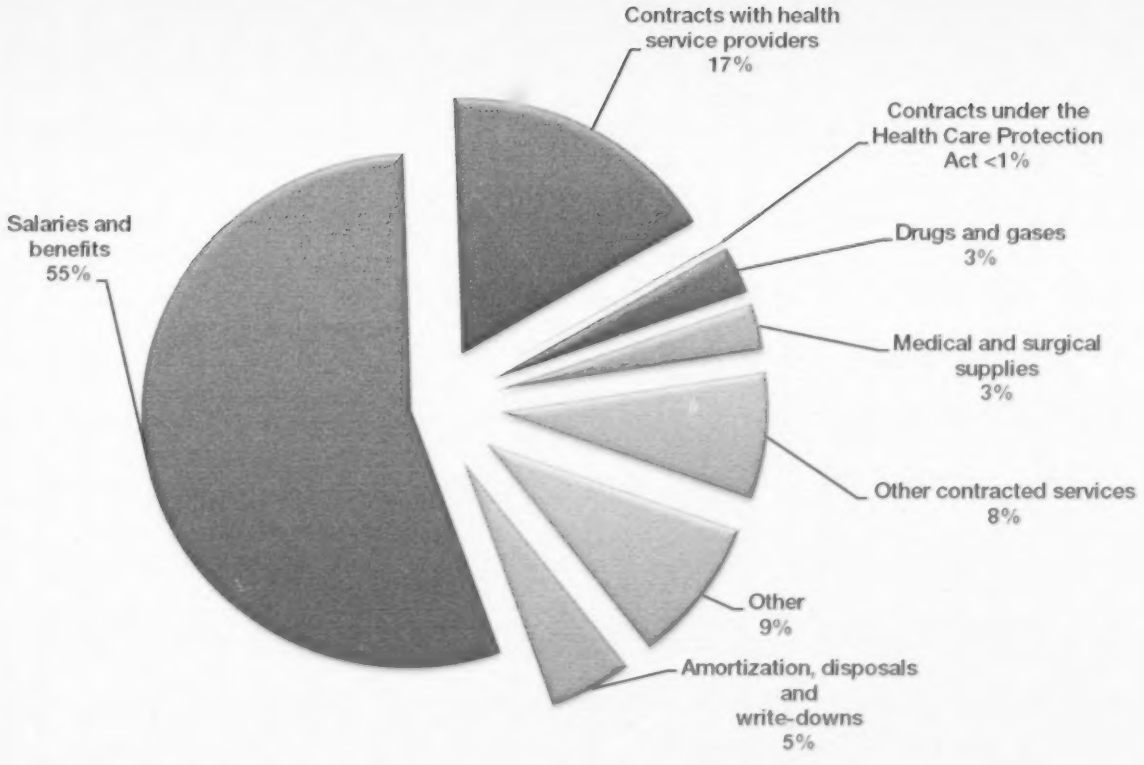
  Compared to the prior year, investment and other income increased by $59 or 23.7% mainly due to higher returns from the Canadian and US equity markets and greater interest income from fixed income investments. The increase is also the result of increased surplus distribution revenue from the WCB, higher GST rebate revenue, and increased activity in programs with physician income guarantee agreements. The overall increase is partly offset by a decrease in miscellaneous income, such as restricted revenue recognized for minor equipment purchases and insurance proceeds.

Expenses – By Function and Object



AHS reviews and reports operating expenses by function and by object in order to fully describe the results of current operations, strategic priorities, and new investments. Operating expenses increased to $13,800 in 2014-15, representing 5.9% growth from the prior year, with the largest percentage increase related to amortization, salaries and benefits, and contracts with health service providers. The growth in expenses includes support for continuing operations, strategic priorities, and the operating requirements of new programs and services. The graph above highlights the most significant areas of operational spending, by function and related objects. A significant portion of the program expenses occurs in inpatient acute nursing services (within which salaries and benefits and other contracted services are the highest objects), emergency and outpatient services (within which salaries and benefits and drugs and gases are the highest objects), facility-based and continuing care services (within which contracts with health service providers and salaries and benefits are the highest objects), community-based care (within which salaries and benefits and contracts with health service providers are the highest objects), diagnostic and therapeutic services (within which salaries and benefits and contracts with health service providers are the highest objects) and support services (within which salaries and benefits, other expenses and amortization are the highest objects).

Expenses – By Object


Contracts with health service providers 17%
Contracts under the Health Care Protection Act <1%
Drugs and gases 3%
Medical and surgical supplies 3%
Other contracted services 8%
Other 9%
Amortization, disposals and write-downs 5%
Salaries and benefits 55%

The overall distribution of expenses by object has remained consistent with prior years with salaries and benefits making up more than half of total expenses (2014 – 54%). AHS continues to focus on priority areas such as access and flow in emergency departments, and adding capacity to continuing care services. Expenses continue to be driven by salaries and benefits, and contracts with health service providers whose costs are also be driven by salaries and benefits.

During 2014-15, AHS incurred unbudgeted costs related to collective agreements and saw increased activity across the province resulting in increased overtime and relief to cover demand. The overall negative expense variance was partially offset by continued challenges in recruiting physicians and staff, timing delays associated with the implementation of various budgeted initiatives, and the achievement of cost containment strategies.

EXPENSES	BUDGET 2015	ACTUAL 2015	VARIANCE 2015		ACTUAL 2014	INCREASE (DECREASE)	
Salaries and benefits	$ 7,348	$ 7,532	$ (184)	(2.5%)	$ 7,049	$ 483	6.9%
Contracts with health service providers	2,354	2,376	(22)	(0.9%)	2,258	118	5.2%
Contracts under the Health care Protection Act	18	19	(1)	(5.6%)	19	-	0.0%
Drugs and gases	428	412	16	3.7%	401	11	2.7%
Medical and surgical supplies	404	403	1	0.2%	390	13	3.3%
Other contracted services	1,152	1,138	14	1.2%	1,090	48	4.4%
Other expenses	1,308	1,287	21	1.6%	1,261	26	2.1%
Amortization, disposals and write-downs	556	633	(77)	(13.8%)	565	68	12.0%
Total expenses	**$ 13,568**	**$ 13,800**	**$ (232)**	**(1.7%)**	**$ 13,033**	**$ 767**	**5.9%**

Significant variances and changes are explained as follows:

- **Salaries and benefits** is composed of compensation for hours worked, vacation and sick leave, other cash benefits (which includes overtime), employer benefit contributions made on behalf of employees, and severance.

  Salaries and benefits amounted to $7,532 compared to a budget of $7,348, resulting in a negative variance of $184 or 2.5%. The negative variance is mainly due to unbudgeted costs related to collective agreements, including those ratified with UNA and HSAA. Higher costs compared to budget were also incurred related to compensation rate variances due to premiums and the use of relief and overtime. The overall variance is also the result of increased activity across all Zones at new facilities and new investments in programs resulting in the need for increased worked hours, overtime, and additional positions not anticipated in the budget. The overall negative variance is partially offset by savings due to vacant positions throughout AHS, including both hard-to-recruit positions and regular recurring vacancies, which also resulted in delays in various initiatives relative to when originally budgeted.

  During the fourth quarter, AHS implemented further cost containment measures, including a management and out-of-scope staff salary freeze and hiring restraint initiative that reviews each vacancy and its involvement in direct patient care. As these measures were implemented near the end of the fiscal year they did not significantly impact the 2014-15 results.

  Compared to the prior year, salaries and benefits increased by $483 or 6.9% mainly due to salary rate and benefit increases primarily related to increases under collective agreements including those ratified during the year with UNA and HSAA. New and existing positions, primarily front line staff, were filled to manage increased activity and capacity throughout the province, including South Health Campus and the opening of the Strathcona Community Hospital. Higher costs were also incurred compared to prior year in order to undertake strategic priority initiatives. Although the number of clinical employees increased compared to the prior year, vacancies persisted throughout AHS resulting in increased costs for overtime and casual relief.

  Compared to the prior year, calculated Full Time Equivalents (FTE) amounted to 75,954 FTE compared to the prior year of 73,366 FTE, resulting in an increase of 2,588 or 3.5%; calculated FTEs are determined by actual hours earned divided by 2,022.75 annual base hours. The overall increase in FTEs is primarily due to increased worked, overtime, and relief hours. The clinical areas account for 45,868 FTEs; Other Staff, which include support services such as food services, facilities and maintenance, clerical staff, and secretarial support, account for 26,703 FTEs. The number of management reporting directly to CEO reports increased as a consequence of a reduction in the senior management layers which eliminated various positions.

- **Contracts with health service providers** include voluntary and private health service providers with whom AHS contracts for health services.

  Contracts with health service providers amounted to $2,376 compared to a budget of $2,354, resulting in a negative variance of $22 or 0.9%. The negative variance is mainly due to unbudgeted costs related to collective agreements. Higher costs compared to budget were also incurred due to increased activity such as increased home care vendor hours to cover demand and the opening of 881 net new continuing care beds and 34 restorative spaces located in acute care. The overall negative variance is partially offset by timing delays associated with the implementation of various budgeted initiatives, including Senior Health Continuing Care Innovations, the Children's Youth Mental Health Sustainability Plan, and the Health Quality Council of Alberta (HQCA) Alternate Level of Care Bed Plan.

  Compared to the prior year, contracts with health service providers increased by $118 or 5.2% mainly due to inflation, resulting in contract rate increases primarily related to lab services, continuing care, mental health, and other specialty contracts. Further contributing to the increased costs was the addition of 881 net new continuing care beds as a result of planned initiatives such as the Capacity Plan and HQCA Alternate Level of Care bed plan, as well as increased activity and collective agreement costs.

- **Contracts under the Health Care Protection Act** relates to contracts with surgical facilities pursuant to the *Health Care Protection Act* which ensures quality while promoting the delivery of publicly funded services by allowing contracting out to profit-orientated surgical facilities.

  Contracts under the Health Care Protection Act amounted to $19 compared to a budget of $18, resulting in a negative variance of $1 or 5.6%.

  Contracts under the Health Care Protection Act costs are unchanged compared to the prior year.

- **Drugs and gases** includes all drugs used by AHS, including medicines, certain chemicals, anaesthetic gas, oxygen, and other medical gases used for patient treatment. Drugs used for other than patient treatment such as diagnostic reagents, are not included in this category, and are reported in other expenses.

  Drugs and gases amounted to $412 compared to a budget of $428, resulting in a positive variance of $16 or 3.7%. The positive variance is mainly due to increased outpatient cancer drug rebates. The overall positive variance is partially offset by increased activity across all Zones and programs resulting in a significant growth in drug utilization, including increased cancer treatments.

  Compared to the prior year, drugs and gases increased by $11 or 2.7% mainly due to increased activity related to cancer treatments, short-term exceptional drug therapy, and specialized high cost drugs. The overall increase is partly offset by increased outpatient cancer drug rebates as compared to the prior year.

- **Medical and surgical supplies** includes prostheses, instruments used in surgical procedures and in treating and examining patients, sutures and other supplies.

  Medical and surgical supplies amounted to $403 compared to a budget of $404, resulting in a positive variance of $1 or 0.2%.

  Compared to the prior year, medical and surgical supplies increased by $13 or 3.3% mainly due to increased activity primarily related to surgical procedures and patient volumes. Further contributing to the increased costs was the implementation of various strategic priority initiatives.

- **Other contracted services** are payments to those under contract that are not considered to be employees. This category includes payments to physicians for referred-out services and purchased services.

  Other contracted services amounted to $1,138 compared to a budget of $1,152, resulting in a positive variance of $14 or 1.2%. The positive variance is mainly due to hard-to-recruit physician vacancies. Further contributing to the positive variance are timing variances associated with the implementation of various budgeted initiatives including the Mental Health Capacity Building projects, Quality Initiative and Health Marketing projects, such as The Big Burn and Human Papillomavirus (HPV) Awareness, as well as the achievement of cost control strategies. The overall positive variance is partially offset by a shortfall in the budget for IT contracted services.

  Compared to the prior year, other contracted services increased by $48 or 4.4% mainly due to higher activity resulting in increased contracted services across the Zones in areas such as diagnostic and therapeutic services, including computed tomography (CT) and magnetic resonance imaging (MRI) exams, stipend payments to physicians, and the opening of the Strathcona Community Hospital during the year. Further contributing to the increase over the prior year is contract inflation and increased core contractual costs related to IT.

- **Other expenses** relate to those not classified elsewhere.

  Other expenses amounted to $1,287 compared to a budget of $1,308, resulting in a positive variance of $21 or 1.6%. The positive variance is mainly due to the achievement of cost containment strategies, including a reduction in travel, education costs and maintenance, the budget assuming higher IT costs than incurred, delays in various budgeted initiatives, and lower than anticipated costs required to support new facilities. The overall positive variance is partially offset by increased insurance expenses associated with losses on claims. Also offsetting the positive variance is an unbudgeted donation made to the World Health Organization to support the Ebola Virus Disease containment and treatment efforts, expiration of inventory related to personal protective equipment, increase in grants awarded to universities, and higher than budgeted expenses for AHS' share of the Primary Care Network expenses.

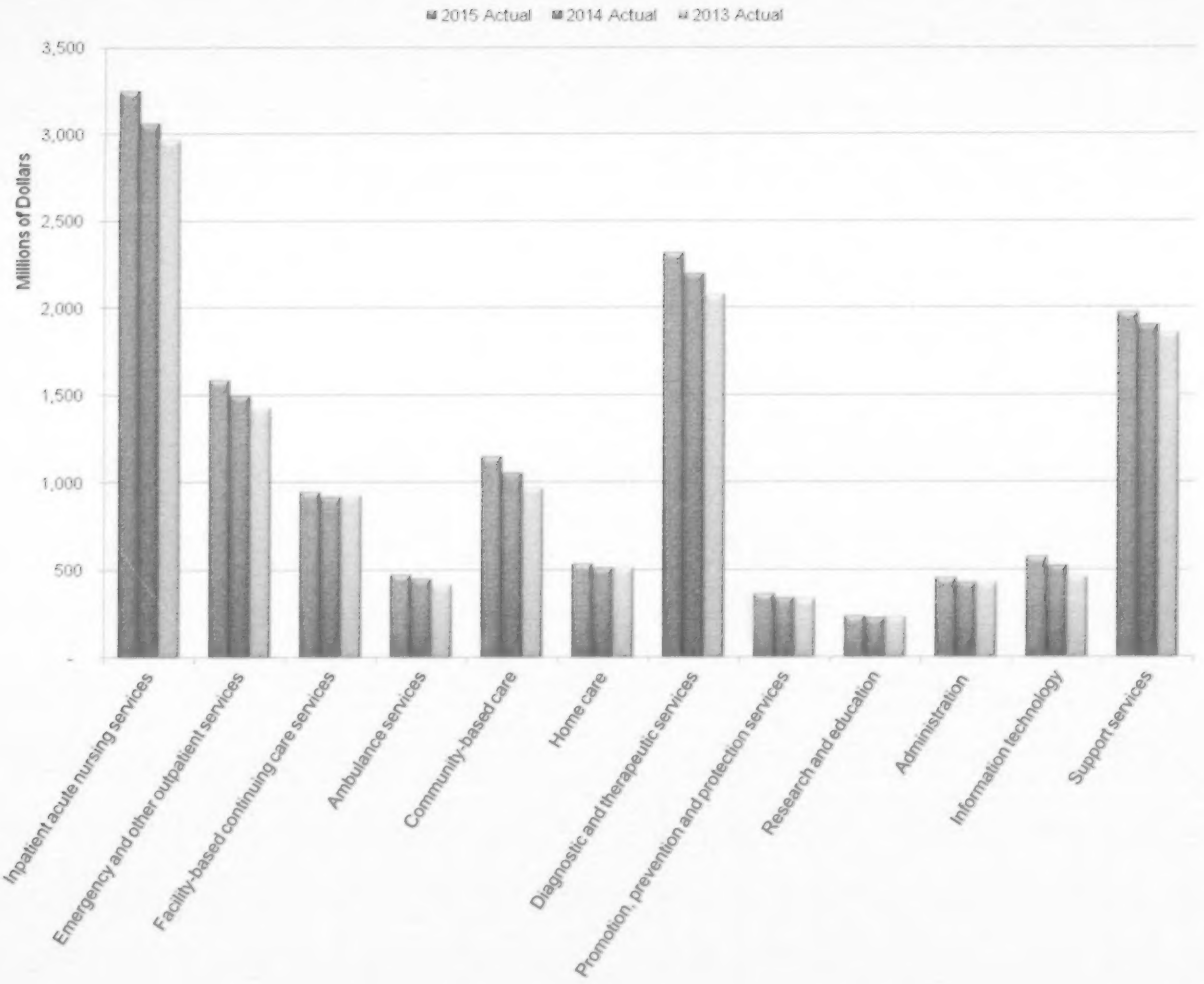
  Compared to the prior year, other expenses increased by $26 or 2.1% mainly due to increased costs related to controlled foundations activities, AHS' share of expenses for the Primary Care Networks, insurance costs, building rent and leasing costs, equipment maintenance, and licenses, fees and memberships. Further contributing to the overall increase was a donation made to the World Health Organization to support the Ebola Virus Disease containment and treatment efforts and the expiration of inventory related to personal protective equipment in the year. The overall increase was partially offset by achieved savings initiatives, including reduced minor equipment purchases, and reduced utility costs as a result of lower natural gas prices.

- **Amortization, disposals and write-downs** relates to the periodic charges to expenses representing the estimated portion of the cost of the respective tangible capital asset that expired through use and age during the period.

  Amortization expenses amounted to $633 compared to a budget of $556 resulting in a negative variance of $77 or 13.8%. The negative variance is mainly due to equipment deployed and capitalized in the year that incurred higher than anticipated amortization compared to budget. The overall variance is also the result of unbudgeted expenditures added to existing tangible capital assets in information systems and AI managed projects. Further contributing to the negative variance is earlier than anticipated capitalization of items, including MRI and CT units, the Personal Health Records system, the South Health Campus IT systems and equipment, and the Ambulatory In-Flight Project.

  Compared to the prior year, amortization expenses increased by $68 or 12.0%, mainly due to the addition of equipment and IT assets as well as the completion and capitalization of various construction projects. Further contributing to the increase from prior year was the addition of assets related to existing AI managed projects.

Expenses – By Function



The overall 5.9% increase in 2014-15 expenses was primarily due to increased salary and benefit costs, amortization expense, contracts with health service provider costs, and patient volumes. AHS' overall distribution of expenses has remained consistent with the previous year, with inpatient acute nursing services and diagnostic and therapeutic expenses making up 40% of total expenses. All areas experienced an increase from the prior year.

Total expenses over the past three years have increased annually due to items such as compensation rates and benefit increases, increased activity, new investments, inflation, and new facilities.

EXPENSES	BUDGET 2015	ACTUAL 2015	VARIANCE 2015		ACTUAL 2014	INCREASE (DECREASE)	
Inpatient acute nursing services	$ 3,067	$ 3,248	$ (181)	(5.9%)	$ 3,058	$ 190	6.2%
Emergency and other outpatient services	1,571	1,582	(11)	(0.7%)	1,488	94	6.3%
Facility-based continuing care services	952	940	12	1.3%	911	29	3.2%
Ambulance services	454	468	(14)	(3.1%)	443	25	5.6%
Community-based care	1,156	1,139	17	1.5%	1,048	91	8.7%
Home care	518	531	(13)	(2.5%)	506	25	4.9%
Diagnostic and therapeutic services	2,301	2,314	(13)	(0.6%)	2,192	122	5.6%
Promotion, prevention and protection services	372	359	13	3.5%	333	26	7.8%
Research and education	238	232	6	2.5%	222	10	4.5%
Administration	477	448	29	6.1%	421	27	6.4%
Information technology	525	568	(43)	(8.2%)	516	52	10.1%
Support services	1,937	1,971	(34)	(1.8%)	1,895	76	4.0%
Total expenses	**$ 13,568**	**$ 13,800**	**$ (232)**	**(1.7%)**	**$ 13,033**	**$ 767**	**5.9%**

Significant variances and changes are explained as follows:

- **Inpatient acute nursing services** is composed predominantly of nursing units such as medical, surgical, intensive care, obstetrics, paediatrics, and mental health. This category also includes operating and recovery rooms.

  Inpatient acute nursing services amounted to $3,248 compared to a budget of $3,067, resulting in a negative variance of $181 or 5.9%. The negative variance is mainly due to unbudgeted costs related to collective agreements including those ratified with UNA and HSAA. Higher costs were also incurred due to increased activity levels in the Zones, including increased patient days, emergency department visits, and surgical activity. Increased activity also resulted in compensation rate variances due to shift premiums and the increased use of overtime and relief, as well as hiring additional unbudgeted staff to meet the increase in demand. The negative variance also includes amortization of capital equipment, which was higher than anticipated. The overall negative variance is partially offset by vacancies related to recruiting physician and staff positions.

  Compared to the prior year, inpatient acute nursing services increased by $190 or 6.2% mainly due to increased compensation costs related to collective agreements, an increase in the number of front line staff, and increased stipends paid to physicians. Further contributing to the increase from prior year is increased activity throughout the organization including increased patient days, emergency department visits, and surgical cases, as well as increased activity at South Health Campus. Additional costs were also incurred to implement planned initiatives and for higher overtime and relief costs.

- **Emergency and other outpatient services** is composed primarily of emergency, day/night care, clinics, day surgery, and contracted surgical services.

  Emergency and other outpatient services amounted to $1,582 compared to a budget of $1,571, resulting in a negative variance of $11 or 0.7%. The negative variance is mainly due to unbudgeted costs related to collective agreements. Further increased costs were incurred related to the use of overtime and higher than anticipated positions required to support new facilities. The variance also includes amortization of capital equipment, which was higher than anticipated. The overall negative variance is partially offset by increased outpatient cancer drug rebates, vacancies, and the achievement of cost containment strategies.

  Compared to the prior year, emergency and other outpatient services increased by $94 or 6.3% mainly due to increased activity resulting in higher demand for cancer drugs, specialized high cost drugs, and increased emergency department visits and surgical activity. Further contributing to the increase from prior year is increased compensation costs related to collective agreements and the opening of the Strathcona Community Hospital during the year.

- **Facility-based continuing care services** is composed of long-term care including chronic and psychiatric care operated by AHS and contracted providers.

  Facility-based continuing care services amounted to $940 compared to a budget of $952, resulting in a positive variance of $12 or 1.3%. The positive variance is mainly due to the achievement of cost control strategies and vacancies. The overall positive variance is partially offset by the unbudgeted costs related to collective agreements.

  Compared to the prior year, facility-based continuing care services increased by $29 or 3.2% mainly due to higher contract costs as a result of inflation and increased compensation costs related to collective agreements.

- **Ambulance services** is composed of Emergency Medical Services (EMS) ambulance, patient transport, and EMS central dispatch.

  Ambulance services amounted to $468 compared to a budget of $454, resulting in a negative variance of $14 or 3.1%. The negative variance is mainly due to the unbudgeted costs related to the ratified collective agreement with HSAA. The negative variance is partially offset by vacancies.

  Compared to the prior year, ambulance services increased by $25 or 5.6% mainly due to rate increases as a result of contract negotiations, hiring additional employees to meet increased activity, and increased compensation costs related to collective agreements.

- **Community-based care** is composed primarily of supportive living, and palliative and hospice care, but excludes community-based dialysis, oncology and surgical services. This category also consists of community programs including Primary Care Networks, Family Care Clinics, urgent care centres, and community mental health.

  Community-based care amounted to $1,139 compared to a budget of $1,156, resulting in a positive variance of $17 or 1.5%. The positive variance is mainly due to vacancies in the Zones and delays in various budgeted initiatives, including Mental Health Capacity Building projects, Seniors Health Continuing Care Innovations and the HQCA Alternate Level of Care Bed Plan. The overall positive variance is partially offset by the unbudgeted costs related to collective agreements.

  Compared to the prior year, community-based care increased by $91 or 8.7% mainly due to implementing initiatives under the Community Capacity Plan and the HQCA Alternate Level of Care Bed Plan, resulting in the opening of new supportive living beds at various facilities. Further increased costs were incurred related to higher activity in the Zones, contract inflation, and increased compensation costs related to collective agreements.

- **Home care** is composed of home nursing and support.

  Home care amounted to $531 compared to a budget of $518, resulting in a negative variance of $13 or 2.5%. The negative variance is mainly due to the unbudgeted costs related to collective agreements. Further contributing to the negative variance was an increase in home care activity across the Zones stemming from increased demand resulting in increased home care hours and the use of relief and overtime. The overall negative variance is offset by vacancies and the budget assuming lower savings initiatives and higher inflation costs than realized.

  Compared to the prior year, home care increased by $25 or 4.9% mainly due to increased compensation costs related to collective agreements, implementation of initiatives, and higher activity resulting in increased home care clients and unique client visits.

- **Diagnostic and therapeutic services** is composed primarily of clinical lab (both in the community and acute), diagnostic imaging, pharmacy, acute and therapeutic services such as physiotherapy, occupational therapy, respiratory therapy and speech language pathology.

  Diagnostic and therapeutic services amounted to $2,314 compared to a budget of $2,301 resulting in a negative variance of $13 or 0.6%. The negative variance is mainly due to the unbudgeted costs related to collective agreements and increased activity across the Zones resulting in the increased use of new cancer drugs, short-term exceptional drug therapy, cancer screening, and physiotherapy. The negative variance also includes amortization of capital equipment which was higher than anticipated mainly due to the timing of MRI and CT unit purchases being earlier in the year than budgeted. The overall negative variance is partially offset by vacancies, including some hard-to-recruit positions, and the achievement of cost containment strategies.

  Compared to the prior year, diagnostic and therapeutic services increased by $122 or 5.6% mainly due to higher activity resulting in increased diagnostic imaging, short-term exception drug therapy, cancer treatments, and lab tests. Increased costs were also incurred for compensation increases related to collective agreements, contract inflation including lab services, and a reduction in vacant positions compared to the prior year.

- **Promotion, prevention and protection services** is composed primarily of health promotion, disease and injury prevention, and health protection.

  Promotion, prevention and protection services amounted to $359 compared to a budget of $372, resulting in a positive variance of $13 or 3.5%. The positive variance is mainly due to delays in various budgeted initiatives, including the purchase of pandemic supplies, Continuing Care Innovations, Health Marketing Projects, Healthy Behaviours and Lifestyles Survey Project, and Access Improvement Measures, as well as vacancies. The overall positive variance is partially offset by the unbudgeted costs related to collective agreements.

  Compared to the prior year, promotion, prevention and protection services increased by $26 or 7.8% mainly due to increased activity levels and the implementation of various initiatives including the Stroke Action Plan, Fragility & Stability projects, Alberta Cancer Prevention initiatives such as the HPV project, and increased compensation costs related to collective agreements.

- **Research and education** pertains to formally organized health research and graduate medical education, primarily funded by donations and third party contributions.

  Research and education amounted to $232 compared to a budget of $238, resulting in a positive variance of $6 or 2.5%. The positive variance is mainly due to lower grant-funded research activity compared to budget, and vacancies. The overall positive variance is partially offset by a decrease in available special purpose funds.

  Compared to the prior year, research and education increased by $10 or 4.5% mainly due to increased compensation and benefit costs and increased research transfers to universities.

- **Administration** is composed of human resources, finance, communications and general administration, as well as a share of administration of certain contracted health service providers. General administration includes senior executive and many functions such as planning and development, infection control, quality assurance, patient safety, insurance, privacy, risk management, internal audit, and legal. Activities and costs directly supporting clinical activities are excluded.

  For 2014-15 AHS' administration expense was $448 which represents 3.2% of total expenses of $13,800.

  The Canadian Institute for Health Information (CIHI) reports administration expense as a financial performance indicator calculated based on administration expense, net of recoveries, and total expenses, net of recoveries and inclusive of bad debt expense. For 2014-15 AHS' indicator was 3.2%.

Administration amounted to $448 compared to a budget of $477, resulting in a positive variance of $29 or 6.1%. The positive variance is mainly due to administrative-related vacancies throughout the organization, partially stemming from the hiring restraint implemented in the later part of the year. Further contributing to the overall positive variance are various delays in budgeted initiatives, including the staff rotation review and optimization initiative, and the achievement of cost containment efforts including reduced travel and education costs. Offsetting the overall positive variance is higher than budgeted insurance expenses associated with losses on claims.

Compared to the prior year, administration increased by $27 or 6.4% mainly due to compensation rate and benefit increases, and increased insurance expenses associated with losses on claims. Further increased costs were incurred due to an increase in AHS' share of administration costs related to certain contracted health service providers compared to the prior year.

- **Information technology** are costs pertaining to the provision of services to design, develop, implement and maintain effective and efficient management support systems in the areas of data processing, systems engineering, technical support, and systems research and development. This includes clinical and corporate enterprise systems and infrastructure, as well as support of provincial systems such as Alberta Netcare.

  Information technology amounted to $568 compared to a budget of $525, resulting in a negative variance of $43 or 8.2%. The negative variance is mainly due to unbudgeted IT costs including planning for the Provincial Clinical Information System, and the budget assuming overall lower operating costs than incurred. Further contributing to the negative variance is fewer IT costs capitalized, the unbudgeted centralization of printer costs to IT, and increased growth in contractual obligations with various external vendors. The overall negative variance is partially offset by vacancies in hard-to-recruit positions and timing variances associated with the implementation of various budgeted initiatives.

  Compared to the prior year, information technology increased by $52 or 10.1% mainly due to new IT initiatives undertaken in the year and increased costs related to ongoing initiatives as they reach support phases, including the Personal Health Portal, Alberta Netcare Portal Release, and Personal Health Record Organ Donor Registry. Further contributing to the increased costs was growth and inflation on various IT vendor contracts, and increased amortization expense related to IT tangible capital assets additions in the year.

- **Support services** is composed of building maintenance operations (including utilities), materials management (including purchasing, central warehousing, distribution and sterilization), housekeeping, laundry and linen services, patient registration, health records, food services, and emergency preparedness.

  Support services amounted to $1,971 compared to a budget of $1,937, resulting in a negative variance of $34 or 1.8%. The negative variance is mainly due to higher than anticipated amortization related to facilities and improvements and unbudgeted expenditures added to existing tangible capital assets related to AI managed projects. Higher costs were also incurred due to unbudgeted costs related to collective agreements. The overall negative variance is partially offset by vacancies, decreased spending, timing variances on the delivery of AI funded Infrastructure Maintenance Projects (IMP), achievement of cost containment strategies, and reduced utility costs.

  Compared to the prior year, support services increased by $76 or 4.0% mainly due to higher amortization expense associated with asset additions from AI managed projects, equipment, and construction projects. Further increased costs were incurred due to increased activity related to leasing costs, overtime and relief, South Health Campus, and increased compensation costs related to collective agreements.

Financial Position

The following table summarizes the Consolidated Statement of Financial Position:

CONSOLIDATED STATEMENT OF FINANCIAL POSITION	2015 ACTUAL	2014 ACTUAL	INCREASE (DECREASE)
Cash and portfolio investments	$ 2,505	$ 2,335	$ 170
Tangible capital assets	7,511	7,502	9
All other assets	549	596	(47)
Total assets	**$ 10,565**	**$ 10,433**	**$ 132**
Deferred revenue			
Unexpended deferred operating revenue	$ 491	$ 499	$ (8)
Unexpended deferred capital revenue	178	230	(52)
Expended deferred capital revenue	6,364	6,277	87
Debt	339	350	(11)
All other liabilities	1,851	1,750	101
Total liabilities	**$ 9,223**	**$ 9,106**	**$ 117**
Accumulated surplus	$ 1,231	$ 1,234	$ (3)
Accumulated remeasurement gains and losses	39	25	14
Endowments	72	68	4
Total net assets	**$ 1,342**	**$ 1,327**	**$ 15**

ACCUMULATED SURPLUS	2015 ACTUAL	2014 ACTUAL	INCREASE (DECREASE)
Unrestricted net assets	$ 272	$ 266	$ 6
Reserves for future purposes	155	87	68
Net assets invested in tangible capital assets	804	881	(77)
Accumulated surplus	**$ 1,231**	**$ 1,234**	**$ (3)**

CASH & PORTFOLIO INVESTMENTS

The Consolidated Statement of Cash Flows summarizes the sources and uses of cash in 2014-15.

AHS receives its base operating funding from AH twice per month. The arrangement allows AHS to manage its operating cash balances effectively to meet its immediate and ongoing liabilities as they become due. The AHS investment portfolio is conservative and highly liquid in nature and enables AHS to react to expected and unexpected cash requirements quickly and efficiently. Focusing on prudent stewardship of funds, AHS monitors its bank balances closely and transfers cash to or from the investment portfolio to ensure that cash balances will earn maximum returns until they need to be utilized.

The increase in cash and portfolio investments of $170 resulted from reinvestment of lower-returning money market securities to fixed income and equity holdings within the portfolio. In addition, reinvested investment income revenues contributed to an increase in the overall investment balance. The portfolio balances of AHS' consolidated entities (consolidated foundations and LPIP) also increased year over year.

The majority of the cash and portfolio investment balance of $2,505 is expected to be used to cover future liabilities including accounts payable, deferred operating and capital costs and long-term borrowing obligations.

AHS manages its cash and portfolio investments prudently so that funds are available to meet current and long-term commitments. As at March 31, 2015, the current balance is appropriate to cover immediate and upcoming obligations as they become due.

Portfolio Composition and Risk Analysis

AHS has a responsibility to ensure its funds are invested in a way that promotes the short- and long-term sustainability of AHS' operations. The investment philosophy assures preservation of capital by minimizing exposure to undue risk of loss or impairment, while maintaining a reasonable expectation of fair return or appreciation while offsetting the effects of inflation.

AHS manages its investment portfolio risk through diversification in various investment vehicles, such as treasury bills, federal, provincial and corporate fixed income, and equity pooled funds. The short-term investment strategy is designed to focus on safety and liquidity, while capturing reasonable rates of return. The longer term strategy balances federal and provincial bonds, high-quality corporate fixed income holdings, and Canadian and Global equity income funds. This strategy protects the original capital while providing reasonable returns with a conservative exposure to more volatile equity markets. The cash equivalents portion of the investment portfolio offsets overall portfolio risk.

TANGIBLE CAPITAL ASSETS

TANGIBLE CAPITAL ASSETS	2015 ACTUAL	2014 ACTUAL	INCREASE (DECREASE)
Cost	$ 13,568	$ 12,992	$ 576
Accumulated amortization	6,057	5,490	567
Net book value	**$ 7,511**	**$ 7,502**	**$ 9**

The total net book value of tangible capital assets as at March 31, 2015 consists of $5,332 of facilities, $818 of equipment and building service equipment, $834 of work in progress (WIP), $349 of information systems, $121 of land and land improvements, and $57 of leased facilities and improvements.

Over the course of the year, several capital projects totalling $422 included in WIP were brought into service. Notable projects included Sturgeon Emergency Room/Ambulatory Care Expansion, Inter-operative MRI Renovations, University of Alberta Hospital Mazankowski Alberta Heart Institute Project, Lloydminster Dr. Cooke Continuing Care Centre, eCRITICAL Alberta Project, Grande Prairie Regional Health Centre, and the Diagnostic Imaging Initiative projects.

The WIP balance includes infrastructure and IT capital projects at:

- Grande Prairie Queen Elizabeth II Hospital
- Northern Lights Regional Health Centre Emergency Room Renovation
- Edson Healthcare Centre
- Strathcona Community Hospital
- High Prairie Health Complex
- South Health Campus (post construction)
- Red Deer Regional Hospital Centre Parkade
- Taber and Raymond Health Centres Redevelopment Project
- Stollery Children's Hospital
- Chinook Regional Hospital
- Peter Lougheed Centre
- Medicine Hat Regional Hospital

At March 31, 2015, AHS has approved capital commitments for purchases of tangible capital assets of $87 for facilities and improvements, $7 for information systems, and $40 for equipment.

The capital purchases compared to the annual amortization expense indicates the rate of reinvestment. The reinvestment rate for equipment and information systems was 46% in 2014-15 (2013-14 – 75%). The reduced rate is due to a decrease in purchases compared to the prior year including fewer IT costs capitalized. As a result, the estimated remaining useful life for equipment and information systems decreased from 3.4 years in 2013-14 to 2.7 years in 2014-15.

Financing of Tangible Capital Assets

AHS primarily relies on external sources for funding capital expenditures. Except for parkades, new facility purchases, including WIP, of $486, were primarily funded by the Alberta government. Equipment purchases, including WIP, of $111, were 47% externally funded (2013-14 – 59%), whereas information system purchases, including WIP, of $45, were only 31% externally funded (2013-14 – 31%).

Expended deferred capital revenue represents purchased tangible capital assets for which AHS has an obligation to utilize for the duration of their economic useful lives. Funding from other government organizations, mainly AI, makes up $5,835 of the $6,364 total balance, while facilities makes up a similar proportion of the total tangible capital assets.

Net assets invested in tangible capital assets included in accumulated surplus is $804, representing the amount of unrestricted net assets used to fund tangible capital assets internally or required to repay debt used to fund tangible capital assets. The majority of the outstanding $339 of debt is used to fund parkade construction.

OTHER ASSETS

Other assets is comprised of accounts receivable, inventories for consumption, prepaid expenses, and other assets. Compared to the prior year, other assets decreased by $47 primarily due to a reduction in accounts receivable related to AH operating grants receivable. The overall decrease is partially offset by an increase in prepaid expenses due to an increase in surpluses held by benefit plans and prepaid maintenance contracts.

DEBT

AHS issues debentures to Alberta Capital Financing Authority (ACFA) to finance the construction of parkades. AHS pledges the revenue derived from all parking facilities as security for the debentures. During the year, net principal repayments of $11 contributed to a decrease from $350 at March 31, 2014 to $339 at March 31, 2015.

As at March 31, 2015, AHS held a $220 revolving demand loan facility with a Canadian chartered bank, which may be used for operating purposes. AHS had no draws on this facility at March 31, 2015.

OTHER LIABILITIES

Other Liabilities is comprised of accounts payable and accrued liabilities and employee future benefits. Compared to the prior year, other liabilities increased by $101 primarily due to an increase in payroll remittances payable and accrued liabilities due to the timing of pay periods at year end, and an increase in the provision for unpaid claims. Further contributing is an increase in employee future benefits due to rate increases in the year.

RESOURCES AVAILABLE FOR FUTURE USE

Transfers, donations, and fundraising are key sources of revenue for AHS. Through these funds, AHS is able to implement various operating and capital initiatives intended to improve the quality of health care in Alberta. Restricted funding subject to timing and purpose restrictions imposed by funding agencies is deferred and recognized as revenue when the terms for the use of the funding are met and, when applicable, AHS complies with its communicated use.

Unexpended deferred operating revenue

During the year, AHS received or accrued, net of repayments, $1,520 in restricted funding and spent $1,601 in related expenses resulting in a decreased deferred operating revenue balance. The amounts received or accrued and spent by AHS pertain primarily to initiatives funded by AH transfers related to physician compensation, incremental operating costs of new health facilities, and the provision of various drugs at no cost to patients. AHS has $491 available as at March 31, 2015 for future restricted use.

Unexpended deferred capital revenue

During the year, AHS received or accrued $517 in restricted capital funding, including $438 of funding from AI, $13 from AH, and $66 from foundations. AHS incurred $515 in expenditures, including $442 for AI, $35 for AH funded initiatives, and $38 through various other foundations. AHS transferred $44 in capital funding to fund operating initiatives, returned $14 in surplus funds from completed projects back to funding agencies, and recognized $4 in unrealized gains on investments. As at March 31, 2015 AHS has $178 available for future restricted capital purposes.

Unrestricted net assets

During the year, AHS' unrestricted net assets increased by $6 primarily due to reduced investment in tangible capital assets. AHS has $272 of unrestricted net assets and $155 of reserves as at March 31, 2015 available for future use.

Financial Reporting, Control and Accountability

FINANCIAL REPORTING

Alberta Health Services was established under the *Regional Health Authorities Act* (Alberta), effective April 1, 2009, as a result of the amalgamation of 12 formerly separate health entities in Alberta.

The AHS consolidated financial statements have been prepared in accordance with PSAS and the financial directives issued by Alberta Health. The chart of accounts that AHS uses to report expenses by program and by object is based on the national standard of CIHI. Detailed site-based results are submitted to CIHI annually for analysis and reporting on Canada's health system and the health of Canadians. AHS quarterly and annual financial reports are available at www.albertahealthservices.ca under data, statistics and reporting.

The Auditor General of Alberta is the appointed auditor of AHS. In addition to expressing an audit opinion on the AHS annual consolidated financial statements, the Auditor General of Alberta also reports to the legislature recommendations related to AHS along with other government entities. The Auditor General of Alberta's reports are available at www.oag.ab.ca under public reports.

FINANCIAL CONTROL AND ACCOUNTABILITY

An effective, integrated governance model is an essential component in support of improving:

- the delivery of care and services to Albertans;
- support for people who deliver care and services; and
- the way the organization operates.

AHS performance measures are aligned with the Alberta Quality Matrix for Health, a framework that provides a common language, understanding and approach for thinking about quality among health-care organizations, professionals and other stakeholders.

The Official Administrator provides oversight and carries out its risk management mandate primarily through sub committees, which include: Audit & Risk Committee, Finance Committee, Quality Assurance & Patient Safety Advisory Committee, and Human Resources Advisory Committee.

During 2014-15, the Audit and Finance Advisory Committee was divided into the Audit & Risk Committee and the Finance Committee. The Audit & Risk Committee has responsibility to assist in fulfilling oversight responsibilities of the Official Administrator with respect to management and compliance, external financial reporting, internal controls over financial reporting, internal audit and the external audit. The Finance Committee has responsibility to assist in fulfilling the financial oversight responsibilities of the Official Administrator and in overseeing management's administration of AHS on finance related items.

AHS has established an Internal Audit function with the mandate of providing independent assurance to management and the Official Administrator on AHS operations. The scope of Internal Audit's work is to determine whether AHS' risk management, control and governance processes are adequate and functioning effectively. The Chief Audit Executive is also responsible for coordinating AHS' Enterprise Risk Management policy and processes for identifying, monitoring and reporting risks within the organization.

As a component of the Internal Audit function, AHS has an Internal Controls over Financial Reporting (ICOFR) group, which is tasked with ensuring that the financial reporting environment mitigates the risk of material misstatements by establishing a sustainable framework of internal controls over financial reporting. In fulfilling its mandate, ICOFR continues to work on the implementation of its plan to ensure that appropriate internal controls are designed, implemented, and documented within AHS.

Four Year Results

CONSOLIDATED STATEMENT OF OPERATIONS YEARS ENDED MARCH 31				
	2015	2014[1]	2013[1]	2012[1]
Revenue:				
Alberta Health transfers				
Base operating grant	$ 10,851	$ 10,496	$ 10,214	$ 9,634
Other operating grants	1,378	1,257	1,068	826
Capital grants	93	87	106	121
Other government transfers	421	387	393	346
Fees and charges	446	432	412	416
Ancillary operations	133	126	118	122
Donations, fundraising, and non- government grants	167	155	144	147
Investment and other income	308	249	190	205
TOTAL REVENUE	13,797	13,189	12,645	11,817
Expenses:				
Inpatient acute nursing services	3,248	3,058	2,965	2,756
Emergency and other outpatient services	1,582	1,488	1,420	1,340
Facility-based continuing care services	940	911	920	892
Ambulance services	468	443	409	395
Community-based care	1,139	1,048	963	873
Home care	531	506	507	453
Diagnostic and therapeutic services	2,314	2,192	2,073	1,960
Promotion, prevention and protection services	359	333	331	308
Research and education	232	222	225	218
Administration	448	421	422	376
Information technology	568	516	455	435
Support services	1,971	1,895	1,849	1,724
TOTAL EXPENSES	13,800	13,033	12,539	11,730
OPERATING SURPLUS (DEFICIT)	$ (3)	$ 156	$ 106	$ 87

SCHEDULE OF EXPENSES BY OBJECT YEARS ENDED MARCH 31				
	2015	2014[1]	2013[1]	2012[1]
Salaries and benefits	$ 7,532	$ 7,049	$ 6,753	$ 6,161
Contracts with health service providers	2,376	2,258	2,166	2,018
Contracts under the Health Care Protection Act	19	19	17	18
Drugs and gases	412	401	364	374
Medical and surgical supplies	403	390	387	357
Other contracted services	1,138	1,090	1,099	1,056
Other	1,287	1,261	1,220	1,271
Amortization, disposals and write-downs	633	565	533	475
TOTAL EXPENSES	$ 13,800	$ 13,033	$ 12,539	$ 11,730

[1] *Certain 2014, 2013 and 2012 amounts have been reclassified to conform to current presentation.*

Forward-Looking Statements Disclosure

The FSD&A includes forward-looking statements and information about the organization's outlook, direction, operations and future financial results that are subject to risks, uncertainties, and assumptions. As a consequence, actual results in the future may differ materially from any conclusion, forecast or projection in such forward-looking statements. Therefore, forward-looking statements should be considered carefully and undue reliance should not be placed on them.

Outlook

LONG-TERM SPENDING TRENDS, COST DRIVERS AND SUSTAINABILITY

For future years, key considerations are:

- Since 2008, AHS' expenses have grown on average by 6.3% per year;
- AHS' most significant cost drivers will continue to be population growth and inflation. These will result in significant cost pressures that must be offset by savings from across all of AHS.

To achieve financial sustainability, AHS will enhance quality, manage cost growth, and ensure value is received for money spent. This will include initiatives in the following areas:

- *Workforce opportunities:* Includes vacancy management and a reduction in overtime costs. Our staff scheduling initiative will increase the continuity of patient care and reduce compensation costs by increasing the percentage of registered nurses (RNs) and licensed practical nurses (LPNs) who work full-time rather than part-time. Currently in Alberta, 31% of RNs and 29% of LPNs work full-time compared to 58% and 42%, respectively, nationally.

- *Benchmarking and service delivery:* Includes a benchmarking review of the 16 largest acute hospitals in Alberta, a review of AHS' management structure, and a review of service delivery models for support services. There are significant opportunities to increase quality and lower costs by learning from high performance groups within Alberta and in other jurisdictions.

- *Administration/ overhead costs/ revenue:* Includes continuing to reduce administration costs and looking to eliminate potential duplication with our partners, subsidiaries, and Alberta Health. Revenue efforts include inflationary increases in fees for non-residents and long-term care accommodation fees.

Key Risks

AHS actively monitors and manages risks that may impact the achievement of its strategic directions. Examples of Enterprise Risk Management (ERM) priority risk areas for AHS include:

- *Sustainable Workforce*: AHS workforce planning needs to take into account changing factors such as patient expectations and requirements, technology, and labour supply. Risk management activities include forecasting and modeling clinical workforce needs and developing strategic workforce plans.

- *Financial Sustainability*: AHS must ensure that financial resources are directed to the highest priorities and manage within approved funding levels. Risk management activities will include implementing activity based funding models, improving processes related to revenue, and undertaking initiatives to control costs such as overtime and sick time.

- *Hospital Acquired Infections*: Hospital-acquired infections are an important cause of morbidity, mortality and increased length of stay while increasing costs of care and impacting capacity. Risk management activities include improving hand hygiene practices and implementing best practices through online manuals and standardized orientation and training materials.

Risk mitigation plans have been developed for all priority risk areas to guide risk management activities.

In addition to the priority risk areas, there are risks specific to the budget. AHS is actively managing these risks and implementing mitigation strategies. These risks include:

- *Compensation*: Salaries and benefits account for a significant proportion of AHS' expenses. Negotiations are underway on two collective agreements with the Alberta Union of Provincial Employees (General Support Services and Auxiliary Nursing).

- *Service pressures*: Increasing demand for health-care services is likely to result in increased expenses. AHS is planning initiatives to ensure appropriate utilization of health care services in the right setting and to ensure quality and patient safety are maintained. AHS' benchmarking initiative will improve operational efficiency without reducing services or quality of services.

- *Cost inflation*: Expenses may be higher than anticipated due to increased cost inflation in areas such as drugs, medical and surgical supplies and contracted services. AHS is working on initiatives to mitigate cost increases, including contract reviews and bulk purchasing, along with work by Strategic Clinical Networks to promote evidence-informed standards.

- *Capital:* AHS has $7.5 billion in capital assets including facilities, equipment and information technology systems. Infrastructure risks include a deferred maintenance backlog with a most recent estimate of $648, and the replacement of aging equipment and technology. AHS collaborates with Alberta Health and Alberta Infrastructure to develop and implement capital plans that will ensure that Alberta's health infrastructure meets existing and evolving service demands.

Alberta Health
Services

CONSOLIDATED FINANCIAL STATEMENTS

MARCH 31, 2015

Alberta Health Services

Management's Responsibility for Financial Reporting

Independent Auditor's Report

Consolidated Statement of Operations

Consolidated Statement of Financial Position

Consolidated Statement of Cash Flows

Consolidated Statement of Accumulated Remeasurement Gains and Losses

Notes to the Consolidated Financial Statements

Schedule 1 – Consolidated Schedule of Expenses by Object

Schedule 2 – Consolidated Schedule of Salaries and Benefits

Alberta Health Services

MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

The accompanying consolidated financial statements for the year ended March 31, 2015 are the responsibility of management and have been reviewed and approved by senior management. The consolidated financial statements were prepared in accordance with Canadian Public Sector Accounting Standards and the financial directives issued by Alberta Health, and of necessity include some amounts based on estimates and judgment.

To discharge its responsibility for the integrity and objectivity of financial reporting, management maintains systems of financial management and internal control which give consideration to costs, benefits and risks that are designed to:

- provide reasonable assurance that transactions are properly authorized, executed in accordance with prescribed legislation and regulations, and properly recorded so as to maintain accountability of public money;
- safeguard the assets and properties of the Province under Alberta Health Services' administration

Alberta Health Services carries out its responsibility for the consolidated financial statements through the Audit & Risk Committee. The Committee meets with management and the Auditor General of Alberta to review financial matters, and recommends the consolidated financial statements to the Alberta Health Services Official Administrator for approval upon finalization of the audit. The Auditor General of Alberta has free access to the Audit & Risk Committee.

The Auditor General of Alberta provides an independent audit of the consolidated financial statements. His examination is conducted in accordance with Canadian Generally Accepted Auditing Standards and includes tests and procedures which allow him to report on the fairness of the consolidated financial statements prepared by management.

[Original Signed By]

Vickie Kaminski
President and Chief Executive Officer
Alberta Health Services

[Original Signed By]

Deborah Rhodes, CA
Vice President Corporate Services and Chief Financial Officer
Alberta Health Services

June 4, 2015

AUDITOR GENERAL *Alberta*

Independent Auditor's Report

To the Official Administrator of Alberta Health Services

Report on the Consolidated Financial Statements

I have audited the accompanying consolidated financial statements of Alberta Health Services, which comprise the consolidated statement of financial position as at March 31, 2015, and the consolidated statements of operations, accumulated remeasurement gains and losses, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on these consolidated financial statements based on my audit. I conducted my audit in accordance with Canadian generally accepted auditing standards. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

In my opinion, the consolidated financial statements present fairly, in all material respects, the financial position of Alberta Health Services as at March 31, 2015, and the results of its operations, its remeasurement gains and losses, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

[Original signed by Merwan N. Saher, FCA]

Auditor General

June 4, 2015

Edmonton, Alberta

CONSOLIDATED STATEMENT OF OPERATIONS
YEAR ENDED MARCH 31

	2015		2014
	Budget (Note 3)	Actual	Actual (Note 26)
Revenue:			
Alberta Health transfers			
Base operating	$ 10,731,000	$ 10,851,204	$ 10,495,788
Other operating	1,459,000	1,378,438	1,257,279
Capital	84,000	92,907	87,173
Other government transfers (Note 4)	402,000	420,599	386,792
Fees and charges	447,000	445,912	432,198
Ancillary operations	127,000	133,118	125,653
Donations, fundraising, and non-government grants (Note 5)	143,000	167,290	155,039
Investment and other income (Note 6)	175,000	308,308	249,120
TOTAL REVENUE	13,568,000	13,797,776	13,189,042
Expenses:			
Inpatient acute nursing services	3,067,000	3,247,819	3,057,753
Emergency and other outpatient services	1,571,000	1,581,887	1,487,854
Facility-based continuing care services	952,000	940,411	911,226
Ambulance services	454,000	468,031	442,848
Community-based care	1,156,000	1,139,337	1,048,466
Home care	518,000	530,501	505,751
Diagnostic and therapeutic services	2,301,000	2,314,445	2,191,895
Promotion, prevention, and protection services	372,000	358,933	333,189
Research and education	238,000	232,162	221,838
Administration (Note 7)	477,000	448,491	420,761
Information technology	525,000	567,792	516,643
Support services (Note 8)	1,937,000	1,970,471	1,895,127
TOTAL EXPENSES (Schedule 1)	13,568,000	13,800,280	13,033,351
OPERATING SURPLUS (DEFICIT)	$ -	(2,504)	155,691
Accumulated surplus, beginning of year		1,233,805	1,078,114
Accumulated surplus, end of year (Note 19)		$ 1,231,301	$ 1,233,805

The accompanying notes and schedules are part of these consolidated financial statements.

CONSOLIDATED STATEMENT OF FINANCIAL POSITION
AS AT MARCH 31

	2015 Actual	2014 Actual
Assets:		
Cash and cash equivalents (Note 11)	$ 549,779	$ 606,070
Portfolio investments (Note 12)	1,955,561	1,728,853
Accounts receivable (Note 13)	313,972	379,245
Other assets	12,179	11,604
Tangible capital assets (Note 14)	7,511,137	7,502,495
Inventories for consumption	96,583	98,252
Prepaid expenses (Note 24)	126,610	106,399
TOTAL ASSETS	$ 10,565,821	$ 10,432,918
Liabilities:		
Accounts payable and accrued liabilities (Note 15)	$ 1,256,333	$ 1,195,016
Employee future benefits (Note 16)	594,603	554,532
Deferred revenue (Note 17)	7,033,031	7,005,555
Debt (Note 18)	339,397	350,368
TOTAL LIABILITIES	9,223,364	9,105,471
Net Assets:		
Accumulated surplus (Note 19)	1,231,301	1,233,805
Accumulated remeasurement gains and losses	38,775	24,846
Endowments (Note 20)	72,381	68,796
TOTAL NET ASSETS	1,342,457	1,327,447
	$ 10,565,821	$ 10,432,918

Contractual Obligations and Contingent Liabilities (Note 21)

The accompanying notes and schedules are part of these consolidated financial statements.

Approved by:

[Original Signed By]

Dr. Carl Amrhein, PhD, RPP, MCIP, FRCGS
Official Administrator
Alberta Health Services

CONSOLIDATED STATEMENT OF CASH FLOWS
YEAR ENDED MARCH 31

	2015 Budget (Note 3)	2015 Actual	2014 Actual (Note 26)
Operating transactions:			
Operating surplus (deficit)	$ -	$ (2,504)	$ 155,691
Non-cash items:			
Amortization, disposals, and write-downs	556,000	633,593	564,926
Recognition of expended deferred capital revenue	(363,000)	(427,506)	(374,317)
Revenue recognized for acquisition of land	-	-	(1,224)
Decrease (increase) in:			
Accounts receivable related to operating transactions	12,000	72,533	(37,073)
Inventories for consumption	3,000	1,669	(4,704)
Other assets	(27,000)	(575)	851
Prepaid expenses	(21,000)	(20,211)	(20,280)
Increase (decrease) in:			
Accounts payable and accrued liabilities related to operating transactions	1,000	85,372	73,690
Employee future benefits	4,000	40,071	29,705
Deferred revenue related to operating transactions	(59,000)	(70,906)	(44,840)
Cash provided by operating transactions	106,000	311,536	342,425
Capital transactions:			
Acquisition of tangible capital assets	(383,000)	(229,734)	(286,015)
Increase (decrease) in accounts payable and accrued liabilities related to capital transactions	236,000	(30,566)	(35,100)
Cash applied to capital transactions	(147,000)	(260,300)	(321,115)
Investing transactions:			
Purchase of portfolio investments	(3,633,000)	(3,134,674)	(3,851,627)
Proceeds on disposals of portfolio investments	3,408,000	2,955,055	3,572,082
Cash applied to investing transactions	(225,000)	(179,619)	(279,545)
Financing transactions:			
Deferred capital revenue received	120,000	96,977	206,276
Deferred capital revenue returned	-	(14,119)	(7,957)
Proceeds from debt	10,000	5,772	-
Principal payments on debt	(15,000)	(16,538)	(18,618)
Cash provided by financing transactions	115,000	72,092	179,701
Net decrease in cash and cash equivalents	(151,000)	(56,291)	(78,534)
Cash and cash equivalents, beginning of year	602,000	606,070	684,604
Cash and cash equivalents, end of year	$ 451,000	$ 549,779	$ 606,070

The accompanying notes and schedules are part of these consolidated financial statements.

CONSOLIDATED STATEMENT OF ACCUMULATED REMEASUREMENT GAINS AND LOSSES
YEAR ENDED MARCH 31

	2015 Actual	2014 Actual
Accumulated remeasurement gains, beginning of year	$ 24,846	$ 10,221
Unrestricted unrealized net gains on portfolio investments	43,724	29,581
Amounts reclassified to the Consolidated Statement of Operations related to portfolio investments	(29,795)	(14,956)
Net remeasurement gains for the year	13,929	14,625
Accumulated remeasurement gains, end of year (Note 12)	$ 38,775	$ 24,846

The accompanying notes and schedules are part of these consolidated financial statements.

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
MARCH 31, 2015

Note 1 Authority, Purpose and Operations

Alberta Health Services (AHS) was established under the *Regional Health Authorities Act* (Alberta), effective April 1, 2009, as a result of the amalgamation of 12 formerly separate health entities in Alberta.

Pursuant to Section 5 of the *Regional Health Authorities Act* (Alberta), AHS is responsible in Alberta to:

- promote and protect the health of the population in the health region and work toward the prevention of disease and injury;
- assess on an ongoing basis the health needs of the health region;
- determine priorities in the provision of health services in the health region and allocate resources accordingly;
- ensure that reasonable access to quality health services is provided in and through the health region; and
- promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities in the health region.

Additionally, AHS is accountable to the Minister of Health (the Minister) for the delivery and operation of the public health system.

The AHS consolidated financial statements include the revenue and expenses associated with its responsibilities. These consolidated financial statements do not reflect the complete costs of provincial health care. For example, the Department of Health is responsible for paying most physician fees. For a complete picture of the costs of provincial healthcare, readers should consult the consolidated financial statements of the Government of Alberta (GOA).

AHS and its contracted health service providers deliver health services at facilities and sites grouped in the following areas: addiction treatment, community mental health, standalone psychiatric facilities, acute care hospitals, sub-acute care in auxiliary hospitals, long-term care, palliative care, supportive living, cancer care, community ambulatory care centres, and urgent care centres.

AHS is exempt from the payment of income taxes under the *Income Tax Act* (Canada).

Note 2 Significant Accounting Policies and Reporting Practices

(a) Basis of Presentation

AHS operates as a Government Not-for-Profit Organization. These consolidated financial statements have been prepared in accordance with Canadian Public Sector Accounting Standards (PSAS) and the financial directives issued by Alberta Health (AH).

These financial statements have been prepared on a consolidated basis and include the following entities:

(i) Controlled Entities

The consolidated financial statements reflect the assets, liabilities, revenues, and expenses of the following entities which are controlled by AHS as at March 31, 2015:

Wholly Owned Subsidiaries:

- Calgary Laboratory Services Ltd. (CLS) - provides medical diagnostic services in Calgary and southern Alberta.
- Capital Care Group Inc. - manages continuing care programs and facilities in the Edmonton area.
- Carewest - manages continuing care programs and facilities in the Calgary area.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Foundations:

Airdrie Health Foundation
Alberta Cancer Foundation (ACF)
Bassano and District Health Foundation
Bow Island and District Health Foundation
Brooks and District Health Foundation
Calgary Health Trust (CHT)
Canmore and Area Health Care Foundation
Cardston and District Health Foundation
Claresholm and District Health Foundation
Crowsnest Pass Health Foundation
David Thompson Health Trust
Fort Macleod and District Health Foundation
Fort Saskatchewan Community Hospital Foundation
Grande Cache Hospital Foundation
Grimshaw/Berwyn Hospital Foundation
Jasper Health Care Foundation
Lacombe Hospital and Care Centre Foundation
Medicine Hat and District Health Foundation
Mental Health Foundation
North County Health Foundation
Oyen and District Health Care Foundation
Peace River and District Health Foundation
Ponoka and District Health Foundation
Stettler Health Services Foundation
Strathcona Community Hospital Foundation
Tofield and Area Health Services Foundation
Vermillion and Region Health and Wellness Foundation
Viking Health Foundation
Vulcan County Health and Wellness Foundation
Windy Slopes Health Foundation

Provincial Health Authorities of Alberta Liability and Property Insurance Plan (LPIP):

AHS consolidates its interest in the LPIP. AHS has the majority of representation on the LPIP's governance board and is therefore considered to control the LPIP. The main purpose of the LPIP is to share the risks of general and professional liability to lessen the impact on any one subscriber.

Other:

Queen Elizabeth II Hospital Child Care Centre

(ii) Government Partnerships

AHS uses the proportionate consolidation method to account for its 50% interest in the Primary Care Network (PCN) government partnerships with physician groups (Note 23), its 50% interest in the Northern Alberta Clinical Trials Centre (NACTRC) partnership with the University of Alberta, and its 30% interest in the HUTV Limited Partnership (HUTV) with David Chittick Management Ltd.

AHS has joint control with various physician groups over PCNs. AHS entered into local primary care initiative agreements to jointly manage and operate the delivery of primary care services, to achieve the PCN business plan objectives, and to contract and hold property interests required in the delivery of PCN services.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

The following PCNs are included in these consolidated financial statements on a proportionate basis:

Alberta Heartland Primary Care Network
Aspen (Athabasca) Primary Care Network
Big Country Primary Care Network
Bonnyville Primary Care Network
Bow Valley Primary Care Network
Calgary Foothills Primary Care Network
Calgary Rural Primary Care Network
Calgary West Central Primary Care Network
Camrose Primary Care Network
Chinook Primary Care Network
Cold Lake Primary Care Network
Drayton Valley Primary Care Network
Edmonton North Primary Care Network
Edmonton Oliver Primary Care Network
Edmonton Southside Primary Care Network
Edmonton West Primary Care Network
Grande Cache Primary Care Network
Grande Prairie Primary Care Network
Highland Primary Care Network
Kalyna Country (Vegreville/Vermillion) Primary Care Network
Lakeland (St. Paul/Aspen) Primary Care Network
Leduc Beaumont Devon Primary Care Network
Lloydminster Primary Care Network
McLeod River Primary Care Network
Mosaic Primary Care Network
Northwest Primary Care Network
Palliser Primary Care Network
Peace Region Primary Care Network
Peaks to Prairies Primary Care Network
Provost/Consort Primary Care Network
Red Deer Primary Care Network
Rocky Mountain House Primary Care Network
Sexsmith/Spirit River Primary Care Network
Sherwood Park - Strathcona County Primary Care Network
South Calgary Primary Care Network
St. Albert & Sturgeon Primary Care Network
Wainwright Primary Care Network
West Peace Primary Care Network
WestView Primary Care Network
Wetaskiwin Primary Care Network
Wolf Creek Primary Care Network
Wood Buffalo Primary Care Network

(iii) Other

These consolidated financial statements include the payments to voluntary and private organizations under contract to provide health services in the Province of Alberta (Note 9). Also included are certain tangible capital assets owned by AHS but operated by contracted health service providers. Other operations not funded by AHS and other assets and liabilities of the contracted health service providers are not included in these consolidated financial statements. These consolidated financial statements also do not include the trust funds administered on behalf of others (Note 25).

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(b) Revenue Recognition

Revenue is recognized in the period in which the transactions or events that give rise to the revenue as described below occur. All revenue is recorded on an accrual basis, except when the accrual cannot be determined within a reasonable degree of certainty or when estimation is impracticable.

(i) Government Transfers

Transfers from AH, other GOA ministries and agencies, and federal government entities are referred to as government transfers.

Government transfers and the associated externally restricted investment income are recorded as deferred revenue if the terms for use of the transfer, or the terms along with AHS' actions and communications as to the use of the transfer, create a liability. These transfers are recognized as revenue as the terms are met and, when applicable, AHS complies with its communicated use of the transfer.

All other government transfers without terms for the use of the transfer are recorded and recognized as revenue when AHS is eligible to receive the funds.

(ii) Donations, Fundraising, and Non-Government Grants

Donations, fundraising, and non-government grants are received from individuals, corporations, and other not-for-profit organizations. Donations, fundraising, and non-government grants may be unrestricted or externally restricted for operating or capital purposes.

Unrestricted donations, fundraising, and non-government grants are recorded as revenue in the year received or in the year the funds are committed to AHS if the amount can be reasonably estimated and collection is reasonably assured.

Externally restricted donations, fundraising, non-government grants, and realized and unrealized gains and losses for the associated externally restricted investment income are recorded as deferred revenue if the terms for their use, or the terms along with AHS' actions and communications as to their use create a liability. These resources are recognized as revenue as the terms are met and, when applicable, AHS complies with its communicated use.

In-kind donations of services and materials are recorded at fair value when such value can reasonably be determined. While volunteers contribute a significant amount of time each year to assist AHS, the value of their services is not recognized as revenue and expenses in the consolidated financial statements because fair value cannot be reasonably determined.

(iii) Grants and Donations of or for Land

AHS records transfers and donations to buy land as a liability when received and recognizes as revenue when AHS buys the land. AHS recognizes in-kind contributions of land as revenue at the fair value of the land when a fair value can be reasonably determined. When AHS cannot determine the fair value, it records such in-kind contributions at nominal value.

(iv) Endowments

Donations, fundraising, government transfers, and non-government grants that must be maintained in perpetuity are recognized as a direct increase in endowment net assets when received or receivable.

All unrealized gains and losses attributable to endowments are recognized as an increase or decrease in deferred revenue.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Expendable realized gains and losses on portfolio investments attributable to endowments are recognized as increases or decreases in deferred revenue when received or receivable and are subsequently recognized in the Consolidated Statement of Operations when terms of use are met, as stipulated by the donors. Realized investment gains on portfolio investments for endowment capital preservation purposes are recognized as a direct increase in endowment net assets when received or receivable.

(v) Fees and Charges, Ancillary Operations, and Other Income

Fees and charges, ancillary operations, and other income are recognized in the period that goods are delivered or services are provided. Cash received for which goods or services have not been provided by year end is recorded as deferred revenue.

(vi) Investment Income

Investment income includes dividend and interest income, and realized gains or losses on the sale of portfolio investments. Unrealized gains and losses on portfolio investments that are not from restricted grants or donations are recognized in the Consolidated Statement of Accumulated Remeasurement Gains and Losses until the related investments are sold. Once realized, these gains or losses are recognized in the Consolidated Statement of Operations. Restricted investment income is recognized as revenue in the period the related expenses are incurred or the terms of use are met.

(c) Expenses

The key elements of AHS' expense recognition policy are:

(i) Expenses are reported on an accrual basis. The cost of all goods consumed and services received during the year are expensed. Interest expense includes debt sourcing costs.

Expenses include grants and transfers under shared cost agreements. Grants and transfers are recorded as expenses when the transfer is authorized and eligibility criteria have been met by the recipient.

(ii) Expenses incurred include contracted health services provided by other entities in support of AHS' responsibilities and operations. These expenses are disclosed in Note 9.

(d) Financial Instruments

All of AHS' financial assets and liabilities are initially recorded at their fair value. The following table identifies AHS' financial assets and liabilities and identifies how they are subsequently measured:

Financial Assets and Liabilities	Subsequent Measurement and Recognition
Cash and cash equivalents and portfolio investments	Measured at fair value with changes in fair values recognized in the Consolidated Statement of Accumulated Remeasurement Gains and Losses, accounts payable, or deferred revenue until realized at which time the cumulative changes in fair value are recognized in the Consolidated Statement of Operations.
Accounts receivable, accounts payable and accrued liabilities and debt	Measured at cost or amortized cost using the effective interest rate method.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

PSAS requires portfolio investments in equity instruments quoted in an active market to be recorded under the fair value category and AHS may choose to record other financial assets under the fair value category if there is an investment strategy to evaluate the performance of a group of these financial assets on a fair value basis. AHS has elected to record its money market securities, fixed income securities, and certain other equity investments at fair value. The three levels of information that may be used to measure fair value are:

- Level 1 - Unadjusted quoted market prices in active markets for identical assets or liabilities;
- Level 2 - Observable or corroborated inputs, other than level 1, such as quoted prices for similar assets or liabilities in inactive markets or market data for substantially the full term of the assets or liabilities; and
- Level 3 - Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets and liabilities.

AHS measures and recognizes embedded derivatives separately from the host contract when the economic characteristics and risk of the embedded derivative are not closely related to those of the host contract, when it meets the definition of a derivative and when the entire contract is not measured at fair value. Embedded derivatives are recorded at fair value. For the year ended March 31, 2015, AHS has no embedded derivatives that require separation from the host contract.

Derivatives are recorded at fair value in the Consolidated Statement of Financial Position. Derivatives with a positive or negative fair value are recognized as increases or decreases to investments. Unrealized gains and losses from changes in the fair value of derivatives are recognized in accumulated remeasurement gains and losses.

All financial assets are assessed for impairment on an annual basis. When a decline is determined to be other than temporary, the amount of the loss is reported as a realized loss on the Consolidated Statement of Operations.

Transaction costs associated with the acquisition and disposal of cash and cash equivalents and portfolio investments are expensed as incurred. Investment management fees are expensed as incurred. The purchase and sale of cash and cash equivalents and portfolio investments are accounted for using trade-date accounting.

(e) Inventories For Consumption

Inventories for consumption or distribution at no charge are valued at lower of cost (defined as moving average cost) and current replacement value.

(f) Tangible Capital Assets

Tangible capital assets and work in progress are recorded at cost, which includes amounts that are directly related to the acquisition, design, construction, development, improvement, or betterment of the assets. Cost includes overhead directly attributable to construction and development as well as interest costs that are directly attributable to the acquisition or construction of the asset. Contributed tangible capital assets and work in progress acquired from other government organizations and other entities are recorded at their fair value on the date of donation. When AHS cannot determine the fair value, in-kind contributions are recorded at a nominal value. Costs incurred by Alberta Infrastructure (AI) to build tangible capital assets on behalf of AHS are recorded by AHS as work in progress and expended deferred capital revenue as AI incurs costs.

Works of art, historical treasures, and collections are expensed when purchased or contributed and not recognized in tangible capital assets.

The threshold for capitalizing new systems development is $250 and major system enhancements is $100. The threshold for all other tangible capital assets is $5. All land is capitalized.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

The cost less residual value of tangible capital assets, excluding land, is amortized over their estimated useful lives on a straight-line basis as follows:

	Useful Life
Facilities and improvements	10-40 years
Equipment	3-20 years
Information systems	3-5 years
Leased vehicles, facilities and improvements	Term of lease
Building service equipment	5-40 years
Land improvements	5-40 years

Work in progress, which includes facility and improvement projects and development of information systems, is not amortized until after a project is substantially complete and the assets are put into service.

Leases transferring substantially all benefits and risks of tangible capital asset ownership are reported as tangible capital asset acquisitions financed by long-term obligations. These capital lease obligations are recorded at the present value of the minimum lease payments excluding executory costs (e.g. insurance, maintenance costs, etc.).

The discount rate used to determine the present value of the lease payments is the lower of AHS' rate for incremental borrowing or the interest rate implicit in the lease. Note 18(c) provides a schedule of repayments and amount of interest on the leases.

Tangible capital assets are written down when conditions indicate that they no longer contribute to AHS' ability to provide goods and services, or when the value of future economic benefits associated with the tangible capital assets are less than their net book value. The net write-downs are accounted for as expenses in the Consolidated Statement of Operations. Write-downs are not reversed.

(g) Employee Future Benefits

(i) Registered Benefit Pension Plans

AHS participates in the following registered defined benefit pension plans: the Local Authorities Pension Plan (LAPP) and the Management Employees Pension Plan (MEPP). These multi-employer public sector defined benefit plans provide pensions for participants based on years of service and final average earnings. Benefits for post-1991 service payable under these plans are limited by the *Income Tax Act* (Canada). The President of Alberta Treasury Board and Minister of Finance is the legal trustee and administrator of the plans. The Department of Treasury Board and Finance accounts for its share of obligations for these pension plans relating to former and current employees of all of the organizations included in the GOA consolidated reporting entity on a defined benefit basis. As a participating government organization, AHS accounts for these plans on a defined contribution basis. Accordingly, the pension expense recorded for these plans in these consolidated financial statements is comprised of the employer contributions that AHS is required to pay for its employees during the fiscal year, which are calculated based on actuarially pre-determined amounts that are expected to provide the plan's future benefits.

(ii) Other Defined Contribution Pension Plans

AHS sponsors Group Registered Retirement Savings Plans (GRRSPs) for certain employee groups. Under the GRRSPs, AHS matches a certain percentage of any contribution made by plan participants up to certain limits. AHS also sponsors a defined contribution pension plan for certain employee groups where the employee and employer each contribute specified percentages of pensionable earnings.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(iii) Supplemental Executive Retirement Plans (SERPs)

AHS sponsors SERPs, which are funded, and has three Retirement Compensation Arrangements (RCA) for these plans. The SERPs cover certain employees and supplement the benefits under AHS' registered plans that are limited by the *Income Tax Act* (Canada). Each plan was closed to new entrants effective April 1, 2009. SERPs provide future pension benefits to participants based on years of service and earnings.

Due to *Income Tax Act* (Canada) requirements, the SERPs are subject to the RCA rules; therefore approximately half the assets are held in a non-interest bearing Refundable Tax Account with the Canada Revenue Agency. The remaining assets of the SERPs are invested in a combination of Canadian equities and Canadian fixed income securities.

The obligations and costs of these benefits are determined annually through an actuarial valuation as at March 31 using the projected benefit method pro-rated on service. AHS uses a discount rate based on plan asset earnings to calculate the accrued benefit obligation.

The net retirement benefit cost of SERPs reported in these consolidated financial statements is comprised of the retirement benefits expense and the retirement benefits interest expense. Costs shown reflect the total estimated cost to provide annual pension income over an actuarially determined post employment period. The key components of retirement benefits expense include the current period benefit cost, cost of any plan amendments including related net actuarial gains or losses incurred in the period, gains and losses from any plan settlements or curtailments incurred in the period, and amortization of actuarial gains and losses. Retirement benefit costs are not cash payments in the period but are the period expense for rights to future compensation. The retirement benefits interest expense is net of the interest cost on the accrued benefit obligation and the expected return on plan assets. The actuarial gains and losses that arise are accounted for in accordance with PSAS whereby AHS amortizes actuarial gains and losses from the liability or asset over the average remaining service life of the related employee group.

Prior period service costs arising from plan amendments are recognized in the period of the plan amendment. When an employee's accrued benefit obligation is fully discharged, all unrecognized amounts associated with that employee are fully recognized in the net retirement benefit cost in the following year.

(iv) Supplemental Pension Plan (SPP)

Subsequent to April 1, 2009, staff eligible for SERP are enrolled in a defined contribution SPP. Similar to the SERP, the SPP supplements the benefits under AHS registered plans that are limited by the *Income Tax Act* (Canada). AHS contributes a certain percentage of an eligible employee's pensionable earnings, in excess of the limits of the *Income Tax Act* (Canada). This plan provides participants with an account balance at retirement based on the contributions made to the plan and investment income earned on the contributions based on investment decisions made by the participant.

(v) Sick Leave Liability

Sick leave benefits accumulate with employees' service and are provided by AHS to certain employee groups of AHS, as defined by employment agreements, to cover illness related absences that are outside of short-term and long-term disability coverage. Benefit amounts are determined and accumulate with reference to employees' final earnings at the time they are paid out. The cost of the accumulating non-vesting sick leave benefits is expensed as the benefits are earned.

AHS accrues its liabilities for accumulating non-vesting sick leave benefits but does not record a liability for sick leave benefits that do not accumulate beyond the current reporting period as these are renewed annually.

The accumulating non-vesting sick leave liability is actuarially determined using the projected benefit method prorated on service and management's best estimates of expected discount rate, inflation, rate of compensation increase, termination and retirement rates, and mortality. The liability associated with these benefits is calculated as the present value of expected future payments pro-rated for service.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Any resulting net actuarial gain (loss) is deferred and amortized on a straight-line basis over the expected average remaining service life of the related employee groups.

(vi) Other Benefits

AHS provides its employees with basic life, accidental death and dismemberment, short-term disability, long-term disability, extended health, dental, and vision benefits through benefits carriers. AHS fully accrues its obligations for employee non-pension future benefits.

(h) Net Assets

Net assets represent the difference between the carrying value of assets held by AHS and its liabilities.

PSAS requires a "net debt" presentation for the Statement of Financial Position in the summary financial statements of government. Net debt presentation reports the difference between financial assets and liabilities as "net debt" or "net financial assets" as an indicator of the future revenue required to pay for past transactions and events. AHS operates within the government reporting entity, and does not finance all of its expenditures by independently raising revenue. Accordingly, these consolidated financial statements do not report a net debt indicator.

(i) Measurement Uncertainty

The consolidated financial statements, by their nature, contain estimates and are subject to measurement uncertainty. Measurement uncertainty exists when there is a variance between the recognized or disclosed amount and another reasonably possible amount. The amount recorded for amortization of tangible capital assets is based on the estimated useful life of the related assets while the recognition of expended deferred capital revenue depends on when the terms for the use of the funding are met and, when applicable, AHS complies with its communicated use of the funding. The amounts recorded for employee future benefits are based on estimated future cash flows. The provision for unpaid claims, allowance for doubtful accounts and accrued liabilities are subject to significant management estimates and assumptions. These estimates and assumptions are reviewed at least annually. Actual results could differ from the estimates determined by management in these consolidated financial statements, and these differences, which may be material, could require adjustment in subsequent reporting periods.

The establishment of the provision for unpaid claims relies on the judgment and opinions of many individuals; historical precedent and trends; prevailing legal, economic, and social and regulatory trends; and expectation as to future developments. The process of determining the provision necessarily involves risks that the actual results will deviate perhaps materially from the best estimates made.

(j) Reserves

Certain amounts, as approved by the Official Administrator, are set aside in accumulated surplus for future operating and capital purposes. Transfers to or from reserves are recorded to the respective reserve when approved.

(k) Change in Accounting Policy

PS 3260 Liability for Contaminated Sites

In June 2010 the Public Sector Accounting Board issued this accounting standard effective for fiscal years starting on or after April 1, 2014. Contaminated sites are a result of contamination being introduced into air, soil, water or sediment of a chemical, organic or radioactive material or live organism that exceeds an environmental standard. AHS adopted this accounting standard retroactively as of April 1, 2014 but without restatement of prior period results. AHS is required to recognize a liability related to the remediation of such contaminated sites subject to certain recognition criteria. For the fiscal year ended March 31, 2015, AHS has not identified any liability for contaminated sites.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(l) Future Accounting Changes

In March 2015 the Public Sector Accounting Board issued PS 2200 – Related party disclosures and PS 3420 – Inter-entity transactions. These accounting standards are effective for fiscal years starting on or after April 1, 2017.

- PS 2200 – Related party disclosures defines a related party and identifies disclosures for related parties and related party transactions, including key management personnel and close family members.
- PS 3420 – Inter-entity transactions, establishes standards on how to account for and report transactions between public sector entities that comprise a government's reporting entity from both a provider and recipient perspective.

AHS will be required to evaluate its disclosures based on the new accounting standards. AHS' management is currently assessing the impact of these new standards on the consolidated financial statements.

Note 3 Budget

The AHS Health Plan and Business Plan 2014-17, which included the 2014-15 annual budget, was approved by the Minister on September 4, 2014.

In 2014-15, AHS reclassified the approved budget for the following due to change in methodology:

(i) $26,000 related to reclassification of rebates from revenue to net against expenses.
(ii) $24,000 related to reclassification of administration expense for contracted health service providers.

	Board Approved Budget	Reclassifications	Reported Budget
Revenue			
Investment and other income	201,000	(26,000)	175,000
Expenses			
Inpatient acute nursing services	3,077,000	(10,000)	3,067,000
Emergency and other outpatient services	1,586,000	(15,000)	1,571,000
Facility-based continuing care services	936,000	16,000	952,000
Community-based care	1,148,000	8,000	1,156,000
Diagnostic and therapeutic services	2,302,000	(1,000)	2,301,000
Administration	501,000	(24,000)	477,000
Expenses by Object			
Drugs and gases	452,000	(24,000)	428,000
Medical and surgical supplies	406,000	(2,000)	404,000

Note 4 Other Government Transfers

	2015	2014
Unrestricted operating transactions	$ 52,760	$ 48,479
Restricted operating transactions	82,578	83,982
Restricted capital transactions	285,261	254,331
	$ 420,599	$ 386,792

Other government transfers include $414,442 (2014 – $378,622) transferred from the GOA and $6,157 (2014 – $8,170) from the federal government, and exclude amounts from AH as these amounts are separately disclosed on the Consolidated Statement of Operations.

Note 5 Donations, Fundraising, and Non-Government Grants

	2015	2014
Unrestricted operating transactions	$ 4,230	$ 10,480
Restricted operating transactions	113,722	111,746
Restricted capital transactions	49,338	32,813
	$ 167,290	$ 155,039

Note 6 Investment and Other Income

	2015	2014
Investment income	$ 98,841	$ 57,757
Other income:		
External recoveries from the GOA (Note 22)	43,809	39,550
Other revenue	165,658	151,813
	$ 308,308	$ 249,120

Other revenue includes revenue related to administrative services provided to others of $11,978 (2014 – $12,065) (Note 7).

Note 7 Administration

	2015	2014
General administration[a]	$ 225,288	$ 207,424
Human resources[b]	99,325	96,821
Finance[c]	65,187	63,657
Communications[d]	16,492	17,309
Direct administration expense incurred by AHS	406,292	385,211
Administration expense of certain contracted health service providers (Note 9)[e]	42,199	35,550
Total administration expense	$ 448,491	$ 420,761
Less revenue related to administrative services provided to others (Note 6)	(11,978)	(12,065)
Net administration expense	$ 436,513	$ 408,696

Net administration expense has been presented to align with the Canadian Institute of Health Information (CIHI) definition. Activities and costs directly supporting clinical activities are not included in administration.

The following are the direct administration expenses incurred by AHS:

(a) General administration includes the Official Administrator expenses, senior leaders' expenses, and other administrative functions such as planning and development, privacy, risk management, internal audit, infection control, quality assurance, insurance, patient safety, and legal.

(b) Human resources includes personnel services, staff recruitment and selection, orientation, labour relations, employee health, and employee record keeping.

(c) Finance includes the recording, monitoring, and reporting of the financial and statistical aspects of AHS' planned and actual activities.

(d) Communications includes the receipt and transmittal of AHS' communications including electronic communication, visitor information, and mail services. It also includes personnel dedicated to maintenance and repair of communication systems and devices.

Note 7 Administration (continued)

In addition, AHS recognizes the following indirect costs as administration expense:

(e) Administrative expense of certain contracted health service providers is AHS' estimate of the portion that AHS funds of the general administration, human resources, finance and communication expenses incurred by voluntary service providers with whom AHS contracts for a full spectrum of health services, the largest being Covenant Health.

Note 8 Support Services

	2015	2014
Facilities operations	$ 800,723	$ 779,972
Patient: health records, food services, and transportation	345,760	335,892
Housekeeping, laundry, and linen	228,181	209,887
Materials management	184,611	172,827
Support services expense of contracted health service providers (Note 9)	113,799	116,496
Ancillary operations	109,604	109,970
Fundraising expenses and grants awarded	38,682	34,089
Emergency preparedness services	3,992	4,536
Other	145,119	131,458
	$ 1,970,471	$ 1,895,127

Note 9 Contracts with Health Service Providers

AHS is responsible for the delivery and operation of the public health system in Alberta. To this end, AHS has contracts with various voluntary and private health service providers to deliver health services throughout Alberta.

	2015	2014
Voluntary health service providers	$ 1,377,957	$ 1,320,027
Private health service providers	997,854	938,015
Total direct AHS funding	$ 2,375,811	$ 2,258,042

The contracts may be for one service such as home care or for the full spectrum of services like Covenant Health who operates several hospitals as well as long-term care facilities. For those contracts that are not for the full spectrum of services, no amount has been allocated to administration.

The direct AHS funding provided is allocated on the Consolidated Statement of Operations according to the services contracted and is as follows:

	2015	2014
Inpatient acute nursing services	$ 303,562	$ 294,230
Emergency and other outpatient services	98,079	97,049
Facility-based continuing care services	601,198	583,698
Ambulance services	167,874	165,451
Community-based care	496,173	440,464
Home care	179,116	169,358
Diagnostic and therapeutic services	357,813	342,309
Promotion, prevention, and protection services	9,535	9,911
Research and education	378	1,291
Administration of certain contract providers (Note 7)	42,199	35,550
Information technology	6,085	2,235
Support services (Note 8)	113,799	116,496
Total allocated expenses	$ 2,375,811	$ 2,258,042

Note 10 Financial Instruments

AHS is exposed to a variety of financial risks associated with the entity's financial instruments. These financial risks include market risk, price risk, interest rate risk, foreign currency risk, credit risk, and liquidity risk.

(a) Market Risk

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. Market risk comprises three types of risk: currency risk, interest rate risk and other price risk.

In order to earn financial returns at an acceptable level of market risk, each of the investment policies have established a targeted asset mix. The AHS Investment Bylaw has established asset mix ranges of 0% to 100% for cash and money market securities, 0% to 80% for fixed income securities, and 0% to 40% for equities.

The ACF Investment Policy has established an asset mix policy of 0% to 10% for money market securities, 30% to 60% for fixed income securities, and 30% to 70% for equities.

The LPIP Investment Policy has established an asset mix policy of 80% to 87% for cash and fixed income securities, 10% to 15% for equities, and 3% to 5% for real estate.

The CHT Statement of Investment Policies and Goals has established an asset mix policy of 30% to 70% for fixed income securities and 30% to 70% for equities.

Risk is reduced under all of the investment policies through asset class diversification, diversification within each asset class, and portfolio quality constraints.

AHS assesses the sensitivity of its portfolio to market risk based on historical volatility of equity and fixed income markets. The volatility is determined using a ten year average based on fixed income and equity market fluctuations and is applied to the total portfolio. Based on the volatility average of 2.55% (2014 – 2.24%) increase or decrease, with all other variables held constant, the increase or decrease in accumulated remeasurement gains and losses would be $43,297 (2014 - $40,155).

(b) Price Risk

Price risk relates to the possibility that equity investments will change in fair value due to future fluctuations in market prices caused by factors specific to an individual equity investment or other factors affecting all equities traded in the market. AHS is exposed to price risk associated with the underlying equity investments held in investment funds. If equity market indices (S&P/TSX, S&P1500 and MSCI ACWI and their sectors) declined by 10%, and all other variables are held constant, the potential loss in fair value to AHS would be approximately 2.30% of total investments (March 31, 2014 – 2.30%).

A 10% change in market value relating to equity securities would have increased or decreased fair value by approximately $44,501 (March 31, 2014 - $41,042).

(c) Interest Rate Risk

Interest rate risk is the risk that the value of a financial instrument might be adversely affected by a change in the market interest rates. Changes in market interest rates may have an effect on the cash flows associated with some financial assets and liabilities, known as cash flow risk, and on the fair value of other financial assets or liabilities, known as price risk. AHS manages the interest rate risk exposure of its fixed income investments by management of average duration and laddered maturity dates.

AHS is exposed to interest rate risk through its investments in fixed income securities with both fixed and floating interest rates. AHS has fixed interest rate loans for all debt, thereby mitigating interest rate risk from rate fluctuations over the term of the outstanding debt. The fair value of fixed rate debt fluctuates with changes in market interest rates but the related future cash flows will not change.

Note 10 Financial Instruments (continued)

In general investment returns for bonds and mortgage funds are sensitive to changes in the level of interest rates, with longer term interest bearing securities being more sensitive to interest rate changes than shorter-term bonds.

A 1% change in market yield relating to fixed income securities would have increased or decreased fair value by approximately $64,682 (March 31, 2014 - $41,733).

Portfolio investments include fixed income securities, such as bonds, and have an average effective yield of 1.61% (2014 - 2.20%) per year maturing between 2015 and 2067. The securities have the following average maturity structure:

	2015	2014
1 – 5 years	72%	78%
6 – 10 years	14%	11%
Over 10 years	14%	11%

	Effective Market Yield			Average Effective
Asset Class	< 1 year	1-5 years	> 5 years	Market Yield
Interest bearing securities	1.14%	1.26%	2.44%	1.61%

(d) Foreign Currency Risk

Foreign currency risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in foreign exchange rates. The fair value of cash and investments denominated in foreign currencies is translated into Canadian dollars using the reporting date exchange rate. AHS is exposed to foreign exchange fluctuations on its cash denominated in foreign currencies. At March 31, 2015 there were no investment balances denominated in foreign currency. Foreign exchange fluctuations on its cash balances are partially mitigated by futures contracts and minimal ending foreign currency cash balances. During the year the effect of these fluctuations was not significant. AHS has policies which provide management with guidance to mitigate foreign currency risk.

Foreign currency risk is managed by the fact that the investment policies limit non-Canadian equities to a maximum of 10% to 45% of the total investment portfolio, depending on the policy. At March 31, 2015, investments in non-Canadian equities represented 5.80% (March 31, 2014 – 5.40%) of total portfolio investments.

At March 31, 2015, AHS held US dollar forward contracts with Alberta Treasury Branch to mitigate its exposure to currency fluctuations relating to US dollar accounts payable. During the year AHS entered into a 12 month forward currency contract to purchase US$2,000 per month at a fixed rate of exchange. As at March 31, 2015, AHS held forward contracts for future settlement of $24,000 (2014 - $nil). The fair value of these forward contracts as at March 31, 2015 was $2,310 (2014 - $nil) and is included in portfolio investments (Note 12).

(e) Credit Risk

Credit risk is the risk of loss arising from the failure of a counterparty to fully honour its financial obligations. The credit quality of financial assets is generally assessed by reference to external credit ratings. Credit risk can also lead to losses when issuers and debtors are downgraded by credit rating agencies. All of the investment policies restrict the types and proportions of eligible investments, thus mitigating AHS' exposure to credit risk.

Accounts receivable primarily consists of amounts receivable from AH, other Alberta government reporting entities, patients, other provinces and territories, Workers' Compensation Board, and the federal government. AHS periodically reviews the collectability of its accounts receivable and establishes an allowance based on its best estimate of potentially uncollectible amounts.

Note 10 Financial Instruments (continued)

Under the AHS Investment Bylaw, money market securities are limited to a rating of R1 or equivalent or higher, and no more than 10% may be invested in any one issuer. Investments in corporate bonds are limited to BBB or equivalent rated bonds or higher and no more than 40% of the total fixed income securities. Investments in debt and equity of any one issuer are limited to 5% of the issuer's total debt and equity. AHS holds unrated mortgage fund investments. Short selling is not permitted.

The ACF Investment Policy limits the overall rating of all fixed income instruments to at least an A rating, and no more than 10% of publically traded equities may be invested in any one issuer.

The LPIP Investment Policy limits money market securities to a rating of R1 or equivalent or higher, and no more than 10% may be invested in any one issuer, unless guaranteed by the Government of Canada or a Canadian province. Investments in corporate bonds are limited to BBB or equivalent rated bonds or higher. Investments in debt and equity of any one issuer are limited to 10% of total equities. LPIP holds unrated mortgage fund investments.

The CHT Statement of Investment Policies and Goals limits the overall rating of fixed income securities to BBB or equivalent or higher, and no more than 10% of fixed income securities or equities may be invested in any one issuer.

The following table summarizes AHS' investment in debt securities by counterparty credit rating at March 31, 2015.

Credit Rating	2015	2014
Investment Grade (AAA to BBB-)	95%	94%
Unrated	5%	6%
	100%	100%

(f) Liquidity Risk

Liquidity risk is the risk that AHS will encounter difficulty in meeting obligations associated with financial liabilities that are settled by delivery of cash or another financial asset. Liquidity requirements of AHS are met through funding in advance by AH, income generated from investments, and by investing in liquid assets, such as money market investments, equities, and bonds, traded in an active market that are easily sold and converted to cash.

Note 11 Cash and Cash Equivalents

	2015	2014
Cash	$ 431,879	$ 186,373
Money market securities less than 90 days	117,900	419,697
Total cash and cash equivalents	$ 549,779	$ 606,070

Cash is comprised of cash on hand and demand deposits. Cash equivalents are short-term, highly liquid investments that are readily convertible to known amounts of cash that are subject to an insignificant risk of change in value. Cash equivalents are held for the purpose of meeting short-term commitments rather than for investment purposes.

Included in cash and cash equivalents is $9,305 (March 31, 2014 – $14,976) that is restricted for use as per the requirements in the *Insurance Act of Alberta*, based on the December 31, 2014 audited financial statements of LPIP.

Cash and cash equivalents include money market securities which are comprised of Government of Canada treasury bills maturing June 2015 and bearing interest at an average yield of 0.71% at March 31, 2015 (2014 – 0.97%).

Note 12 Portfolio Investments

	2015		2014	
	Fair Value	Cost	Fair Value	Cost
Money market securities greater than 90 days	$ 1,573	$ 1,573	$ 27,898	$ 27,898
Fixed income securities	1,508,906	1,472,452	1,290,533	1,280,753
Equities	445,082	364,979	410,422	350,735
Total portfolio investments	$ 1,955,561	$ 1,839,004	$ 1,728,853	$ 1,659,386

Included in the portfolio investments is $140,422 (March 31, 2014 – $112,432) that is restricted for use as per the requirements in the *Insurance Act of Alberta*, based on the December 31, 2014 audited financial statements of LPIP.

As AHS is made up of multiple entities as described in Note 2(a), portfolio investments are governed independently under multiple investment policies and procedures. The fair value of portfolio investments governed under each investment policy is as follows:

	2015	2014
AHS Investment Bylaw	$ 1,620,210	$ 1,411,162
ACF Investment Policy	149,200	126,554
LPIP Investment Policy	140,422	112,432
CHT Statement of Investment Policies and Goals	45,729	78,705
	$ 1,955,561	$ 1,728,853

Portfolio investments are measured at fair value with the differences between cost and fair value being recorded as a remeasurement gain or loss. The following are the total net remeasurement gains/(losses) on portfolio investments:

	2015	2014
Accumulated remeasurement gains	$ 38,775	$ 24,846
Restricted unrealized net gains attributable to endowments and portfolio investments related to unexpended deferred operating revenue (Note 17(b))	58,325	35,729
Restricted unrealized net gains attributable to and recorded in:		
Unexpended deferred capital revenue (Note 17(d))	10,288	6,236
Accounts payable and accrued liabilities (Note 15)	9,169	2,656
	$ 116,557	$ 69,467

Fair Value Hierarchy

	2015		
	Level 1	Level 2	Total
Equities traded in active market	$ 358,251	$ -	$ 358,251
Fixed income securities, mortgage, real estate funds, and other equities	-	1,597,310	1,597,310
March 31, 2015 total amount	$ 358,251	$ 1,597,310	$ 1,955,561
Percent of total	18%	82%	100%

	2014		
	Level 1	Level 2	Total
Equities traded in active market	$ 365,879	$ -	$ 365,879
Fixed income securities, mortgage, real estate funds, and other equities	-	1,362,974	1,362,974
March 31, 2014 total amount	$ 365,879	$ 1,362,974	$ 1,728,853
Percent of total	21%	79%	100%

Note 13 Accounts Receivable

	2015			2014
	Gross Amount	Allowance for Doubtful Accounts	Net Realizable Value	Net Realizable Value
Patient accounts receivable	$ 129,118	$ 28,528	$ 100,590	$ 89,178
AH operating grants receivable	44,426	-	44,426	105,668
AH capital grants receivable	1,200	-	1,200	-
Other operating grants receivable	28,683	-	28,683	42,337
Other capital grants receivable	85,417	-	85,417	79,357
Other accounts receivable	53,808	152	53,656	62,705
	$ 342,652	$ 28,680	$ 313,972	$ 379,245

Accounts receivable are unsecured and non-interest bearing. At March 31, 2014, the total allowance for doubtful accounts was $24,637.

Note 14 Tangible Capital Assets

Historical cost	2014	Additions[a]	Transfers into (out of) work-in-progress	Disposals and write-downs[b]	2015
Facilities and improvements	$ 8,130,294	$ -	$ 157,206	$ -	$ 8,287,500
Work in progress	725,179	531,423	(422,274)	-	834,328
Equipment	2,126,628	100,948	(4,435)	(37,146)	2,185,995
Information systems	1,213,446	9,864	155,307	(29,190)	1,349,427
Building service equipment	446,910	-	92,542	-	539,452
Land	110,069	-	-	-	110,069
Leased facilities and improvements	172,196	-	19,670	-	191,866
Land improvements	67,717	-	1,984	(553)	69,148
	$ 12,992,439	$ 642,235	$ -	$ (66,889)	$ 13,567,785

Accumulated amortization	2014	Amortization expense	Effect of transfers	Effect of disposals and write-downs[b]	2015
Facilities and improvements	$ 2,717,992	$ 237,856	$ -	$ -	$ 2,955,848
Work in progress	-	-	-	-	-
Equipment	1,448,349	190,752	-	(36,591)	1,602,510
Information systems	879,342	150,053	-	(28,786)	1,000,609
Building service equipment	267,084	37,826	-	-	304,910
Land	-	-	-	-	-
Leased facilities and improvements	121,621	13,198	-	-	134,819
Land improvements	55,556	2,550	-	(154)	57,952
	$ 5,489,944	$ 632,235	$ -	$ (65,531)	$ 6,056,648

	Net Book Value	
	2015	2014
Facilities and improvements	$ 5,331,652	$ 5,412,302
Work in progress	834,328	725,179
Equipment	583,485	678,279
Information systems	348,818	334,104
Building service equipment	234,542	179,826
Land	110,069	110,069
Leased facilities and improvements	57,047	50,575
Land improvements	11,196	12,161
	$ 7,511,137	$ 7,502,495

Note 14 Tangible Capital Assets (continued)

(a) Transferred Tangible Capital Assets

Additions include non-cash work in progress for a total of $412,706 (2014 - $270,698).

(b) Disposals and Write-Downs

Disposals and write-downs include disposals of $66,439 and a write-down of a facility at a cost of $450 (2014 - disposals of $107,839 and write-downs of information systems of $20,105) with an effect to accumulated amortization for disposals of $65,385 and write-downs of $146 (2014 - disposals of $106,614 and write-downs of $17,482).

(c) Leased Land

Land at the following sites has been leased to AHS at nominal values:

Site	Leased from	Lease expiry
Cross Cancer Institute Parkade	University of Alberta	2019
Evansburg Community Health Centre	Yellowhead County	2031
Two Hills Helipad	Stella Stefiuk	2041
McConnell Place North	City of Edmonton	2044
Northeast Community Health Centre	City of Edmonton	2046
Foothills Medical Centre Parkade	University of Calgary	2054
Alberta Children's Hospital	University of Calgary	2103

(d) Leased Equipment

Equipment includes assets acquired through capital leases at a cost of $17,037 (2014 - $17,499) with accumulated amortization of $12,294 (March 31, 2014 - $12,058). Equipment additions for the year ended March 31, 2015 include a net decrease of $205 related to vehicle capital leases (2014 – net decrease of $6,398).

Note 15 Accounts Payable and Accrued Liabilities

	2015	2014
Payroll remittances payable and accrued liabilities	$ 680,324	$ 597,282
Trade accounts payable and accrued liabilities[a]	385,667	439,867
Provision for unpaid claims[b]	138,525	115,968
Other liabilities	42,648	39,243
	1,247,164	1,192,360
Unrealized net gains on portfolio investments related to accounts payable and accrued liabilities (Note 12)	9,169	2,656
	$ 1,256,333	$ 1,195,016

(a) Trade Accounts Payable and Accrued Liabilities

Trade accounts payable and accrued liabilities includes payables related to the purchase of tangible capital assets of $62,923 (2014 - $93,489).

(b) Provision for Unpaid Claims

Provision for unpaid claims represents the losses from identified claims likely to be paid and provisions for liabilities incurred but not yet reported.

The provision has been estimated using the discounted value of claim liabilities using a discount rate of 2.15% (2014 - 2.50%) plus a provision for adverse deviation, based on actuarial estimation.

Note 16 Employee Future Benefits

	2015	2014
Accrued vacation pay	$ 493,845	$ 458,513
Accumulating non-vesting sick leave liability[a]	100,758	96,019
Registered defined benefit pension plans[b][c]	-	-
	$ 594,603	$ 554,532

(a) Accumulating Non-Vesting Sick Leave Liability

Sick leave benefits are paid by AHS; there are no employee contributions and no plan assets.

The AHS sick leave liability is based on an actuarial valuation as at March 31, 2015. The AHS sick leave liability for the year ended March 31, 2014 is based on an extrapolated actuarial valuation as at March 31, 2011.

The following table summarizes the accumulating non-vesting sick leave liability.

	2015	2014
Change in accrued benefit obligation and funded status		
Accrued benefit obligation and funded status, beginning of year	$ 97,132	$ 99,465
Current service cost	8,884	8,408
Interest cost	3,871	3,430
Plan amendments	-	287
Benefits paid	(8,243)	(7,898)
Actuarial (gain) loss	13,335	(6,560)
Accrued benefit obligation and funded status, end of year	$ 114,979	$ 97,132
Reconciliation to accrued benefit liability		
Funded status - deficit	$ 114,979	$ 97,132
Unamortized net actuarial loss	(14,221)	(1,113)
Accrued benefit liability	$ 100,758	$ 96,019
Components of expense		
Current service cost	$ 8,884	$ 8,408
Interest cost	3,871	3,430
Amortization of net actuarial loss	227	776
Recognition of past service costs	-	287
Net expense	$ 12,982	$ 12,901
Assumptions		
Discount rate – beginning of year	3.80%	3.30%
Discount rate – end of year	2.90%	3.80%
Rate of compensation increase per year	2014-2015	2013-2014
	0.25%	3.25%
	2015-2016	2014-2015
	3.21%	0.25%
	Thereafter 3.25%	Thereafter 3.25%

Note 16 Employee Future Benefits (continued)

(b) Local Authorities Pension Plan (LAPP)

(i) AHS Participation in the LAPP

The majority of AHS employees participate in the LAPP. AHS is not responsible for future funding of the plan deficit other than through contribution increases. As AHS is exposed to the risk of contribution rate increases, the following disclosure is provided to explain this risk.

The LAPP provides for a pension of 1.4% for each year of pensionable service based on the average salary of the highest five consecutive years up to the average Canada Pension Plan's Year's Maximum Pensionable Earnings (YMPE) over the same five consecutive year period and 2.0% on the excess, subject to the maximum pension benefit limit allowed under the *Income Tax Act* (Canada). The maximum pensionable service allowable under the plan is 35 years.

The contribution rates were reviewed by the LAPP Board of Trustees in 2014 and are to be reviewed at least once every three years based on a report prepared by LAPP's actuary. AHS and its employees made the following contributions:

Calendar 2014		Calendar 2013	
Employer	Employees	Employer	Employees
$541,683	$500,179	$483,270	$442,720
11.39% of pensionable earnings up to the YMPE and 15.84% of the excess	10.39% of pensionable earnings up to the YMPE and 14.84% of the excess	10.43% of pensionable earnings up to the YMPE and 14.47% of the excess	9.43% of pensionable earnings up to the YMPE and 13.47% of the excess

AHS contributed $541,683 (2013 - $483,270) of the LAPP's total employer contributions of $1,227,346 from January 1, 2014 to December 31, 2014 (December 31, 2013 - $1,076,067).

(ii) LAPP Deficit

An actuarial valuation of the LAPP was carried out as at December 31, 2013 by Mercer (Canada) Limited and these results were then extrapolated to December 31, 2014 for use in the LAPP 2014 audited financial statements. LAPP's net assets available for benefits divided by LAPP's pension obligation shows that the LAPP is 93% (2013 - 85%) funded.

	December 31, 2014	December 31, 2013
LAPP net assets available for benefits	$ 30,790,364	$ 26,550,184
LAPP pension obligation	33,245,000	31,411,700
LAPP deficiency	$ (2,454,636)	$ (4,861,516)

The 2015 and 2016 LAPP contribution rates are as follows:

Calendar 2016 (estimated)[i]		Calendar 2015	
Employer	Employees	Employer	Employees
11.39% of pensionable earnings up to the YMPE and 15.84% of the excess	10.39% of pensionable earnings up to the YMPE and 14.84% of the excess	11.39% of pensionable earnings up to the YMPE and 15.84% of the excess	10.39% of pensionable earnings up to the YMPE and 14.84% of the excess

i) The 2016 LAPP contribution rates are estimates and subject to change.

Note 16 Employee Future Benefits (continued)

(c) Management Employees Pension Plan (MEPP)

At December 31, 2014 the MEPP reported a surplus of $75,805 (December 31, 2013 - surplus of $50,457).

(d) Supplemental Executive Retirement Plans (SERPs)

The obligations and costs of SERPs benefits are based on an actuarial valuation as at March 31, 2015.

As at March 31, 2015 an accrued benefit liability of $1,713 is included in accounts payable and accrued liabilities (March 31, 2014 - $1,242).

AHS sponsors SERPs which are funded and has three RCAs for these plans. Under the terms of the SERPs, participants will receive retirement benefits that supplement the benefits under AHS' registered plans that are limited by the *Income Tax Act* (Canada). As required under the plans' terms, any unfunded obligations identified in the actuarial valuation completed at the end of each fiscal year must be fully funded within 61 days. Based on the most recent actuarial valuation for the purpose of establishing the minimum funding contribution, the SERPs are fully funded as at March 31, 2015.

	2015	2014
Change in accrued benefit obligation		
Accrued benefit obligation, beginning of year	$ 43,430	$ 44,709
Current service cost	-	133
Interest cost	1,183	1,201
Benefit payments	(2,683)	(3,926)
Actuarial losses	40	1,313
Accrued benefit obligation, end of year	$ 41,970	$ 43,430
Change in plan assets		
Market value of plan assets, beginning of year	$ 41,280	$ 43,582
Actual return on plan assets	1,979	1,571
Actual employer contributions	493	53
Benefit payments	(2,683)	(3,926)
Fair value of plan assets, end of year	$ 41,069	$ 41,280
Reconciliation of funded status to accrued benefit asset (liability)		
Funded status of the plan	$ (901)	$ (2,150)
Unamortized net actuarial loss (gains)	(812)	908
Accrued benefit liability, end of year	$ (1,713)	$ (1,242)

A portion of SERP is secured by a letter of credit held by the trustee and a refundable tax balance held by the federal government. The required amount of the letter of credit during the year was $3,100 (2014 - $2,973).

Note 16 Employee Future Benefits (continued)

Net actuarial gains or losses are amortized over a period of one year.

	2015	2014
Determination of net benefit cost		
Current period benefit cost	$ -	$ 133
Amortization of actuarial losses (gains)	908	(508)
Interest cost on the accrued benefit obligation	1,183	1,201
Expected return on plan assets	(1,127)	(1,166)
Net benefit cost	$ 964	$ (340)
Change in actuarial assumption for discount rate	$ -	$ -
Members		
Active	35	35
Retired and terminated	59	59
Total members	94	94
Assumptions		
Weighted average discount rate to determine year end obligations	2.70%	2.80%
Weighted average discount rate to determine net benefit costs	2.80%	2.75%
Expected return on assets	2.80%	2.75%
Expected average remaining service life time	1	1
Rate of compensation increase per year	2014-2015	2013-2014
	0.00%	0.00%
	Thereafter	Thereafter
	0.00%	0.00%

(e) Pension expense

	2015	2014
Local Authorities Pension Plan	$ 547,676	$ 498,110
Defined contribution pension plans and group RRSPs	45,575	44,930
Supplemental Pension Plan	2,795	1,866
Supplemental Executive Retirement Plans	964	(340)
Management Employees Pension Plan	691	631
	$ 597,701	$ 545,197

Note 17 Deferred Revenue

	2015	2014
Unexpended deferred operating revenue[a][b]	$ 491,254	$ 499,231
Unexpended deferred capital revenue[c][d]	178,078	229,855
Expended deferred capital revenue[e]	6,363,699	6,276,469
	$ 7,033,031	$ 7,005,555

(a) Unexpended deferred operating revenue represents unspent resources with stipulations or external restrictions related to operating expenditures. Changes in the unexpended deferred operating revenue balance are as follows:

	2015				2014
	AH	Other government[i]	Donors and non-government	Total	Total
Balance, beginning of year	$ 209,658	$ 41,758	$ 247,815	$ 499,231	$ 483,953
Received or receivable during the year, net of repayments	1,347,230	40,085	132,286	1,519,601	1,426,091
Restricted investment income	328	2,364	4,648	7,340	6,273
Transferred from (to) unexpended deferred capital revenue	20,900	24,809	(1,792)	43,917	44,824
Recognized as revenue from funder	(1,378,438)	(82,578)	(113,722)	(1,574,738)	(1,453,007)
Recognized as revenue from other sources	(379)	(36)	(26,278)	(26,693)	(27,786)
	199,299	26,402	242,957	468,658	480,348
Changes in unrealized net gain attributable to endowments and portfolio investments related to unexpended deferred operating revenue	4,428	975	17,193	22,596	18,883
Balance, end of year	$ 203,727	$ 27,377	$ 260,150	$ 491,254	$ 499,231

[i] The balance at March 31, 2015 for other government includes $973 of unexpended deferred operating revenue received from the federal government (March 31, 2014 - $1,213). The remaining balance all relates to the GOA, see Note 22.

Note 17 Deferred Revenue (continued)

(b) The unexpended deferred operating revenue balance at the end of the year is stipulated or externally restricted for the following purposes:

	2015				2014
	AH	Other government	Donors and non-government	Total	Total
Research and education	$ 509	$ 3,135	$ 118,475	$ 122,119	$ 124,276
Cancer prevention, screening and treatment	30,143	81	56,352	86,576	87,034
Primary Care Networks	71,152	-	78	71,230	64,179
Promotion, prevention and community	22,330	1,121	3,016	26,467	32,607
Physician revenue and alternate relationship plans	21,663	913	-	22,576	34,324
Addiction and mental health	18,865	1,179	5	20,049	24,558
Long term care partnerships	-	13,230	-	13,230	10,800
Information technology	11,432	130	177	11,739	4,270
Continuing care and seniors health	7,282	1,224	1,513	10,019	11,436
Administration and support services	1,458	1,787	3,631	6,876	11,428
Inpatient acute nursing services	262	72	3,184	3,518	12,060
Others less than $10,000	8,554	2,246	27,730	38,530	46,530
	193,650	25,118	214,161	432,929	463,502
Unrealized net gain attributable to endowments and portfolio investments related to unexpended deferred operating revenue (Note 12)	10,077	2,259	45,989	58,325	35,729
	$ 203,727	$ 27,377	$ 260,150	$ 491,254	$ 499,231

Note 17 Deferred Revenue (continued)

(c) Unexpended deferred capital revenue represents unspent resources with stipulations or external restrictions related to the purchase of tangible capital assets. Changes in the unexpended deferred capital revenue balance are as follows:

	2015				2014
	AH	Other government[(i)]	Donors and non-government	Total	Total
Balance, beginning of year	$ 118,444	$ 38,968	$ 72,443	$ 229,855	$ 240,358
Received or receivable during the year	13,272	24,947	65,778	103,997	184,880
Transferred tangible capital assets (Note 14(a))	-	412,623	83	412,706	270,698
Restricted investment income	240	-	-	240	147
Unexpended deferred capital revenue returned	(308)	-	(13,811)	(14,119)	(7,957)
Transfer to expended deferred capital revenue	(35,081)	(442,241)	(37,414)	(514,736)	(414,298)
Transferred (to) from unexpended deferred operating revenue	(20,900)	(24,809)	1,792	(43,917)	(44,824)
Used for the acquisition of land	-	-	-	-	(1,224)
	75,667	9,488	88,871	174,026	227,780
Changes in unrealized net gain on portfolio investments related to unexpended deferred capital revenue	2,199	350	1,503	4,052	2,075
Balance, end of year	$ 77,866	$ 9,838	$ 90,374	$ 178,078	$ 229,855

[(i)] All balances relate to the GOA, see Note 22.

Note 17 Deferred Revenue (continued)

(d) The unexpended deferred capital revenue balance at the end of the year is stipulated or externally restricted for the following purposes:

	2015	2014
AH		
Information systems:		
Diagnostic Imaging Upgrade Project	$ 8,698	$ 10,040
Regional Shared Health Information Program	4,766	6,297
Access to Health Service Information Management / Information Technology	3,311	9,808
Provincial Health Information Exchange	3,011	7,910
Information systems less than $10,000	32,801	46,182
	52,587	80,237
Medical Equipment Replacement Upgrade Program	11,707	22,650
Equipment less than $10,000	7,477	11,061
Total AH	71,771	113,948
Other government		
Facilities and improvements:		
Infrastructure maintenance projects	-	25,197
Facilities and improvements less than $10,000	8,371	12,654
Total other government	8,371	37,851
Donors and non-government		
Equipment less than $10,000	86,995	59,159
Facilities and improvements less than $10,000	653	12,661
Total donors and non-government	87,648	71,820
Unrealized net gain on portfolio investments related to unexpended deferred capital revenue (Note 12)	10,288	6,236
	$ 178,078	$ 229,855

(e) Expended deferred capital revenue represents external resources spent in the acquisition of tangible capital assets, stipulated for use in the provision of services over their useful lives. Revenue is recognized over the useful life of the assets. Changes in the expended deferred capital revenue balance are as follows:

	2015				2014
	AH	Other government[1]	Donors and non-government	Total	Total
Balance, beginning of year	$ 407,657	$ 5,678,020	$ 190,792	$ 6,276,469	$ 6,235,264
Transferred from unexpended deferred capital revenue	35,081	442,241	37,414	514,736	414,298
Used for the acquisition of land	-	-	-	-	1,224
Less: amounts recognized as revenue	(92,907)	(285,261)	(49,338)	(427,506)	(374,317)
Balance, end of year	$ 349,831	$ 5,835,000	$ 178,868	$ 6,363,699	$ 6,276,469

[1] All balances relate to the GOA, see Note 22.

Note 18 Debt

	2015	2014
Debentures payable[(a)]:		
Parkade loan #1	$ 37,469	$ 39,925
Parkade loan #2	34,639	36,681
Parkade loan #3	43,664	45,790
Parkade loan #4	160,585	166,778
Parkade loan #5	38,737	40,207
Parkade loan #6	5,000	-
Obligation under leased tangible capital assets[(b)]	17,562	19,002
Other	1,741	1,985
	$ 339,397	$ 350,368

(a) AHS issued debentures to Alberta Capital Financing Authority (ACFA), a related party, to finance the construction of parkades. AHS has pledged revenue derived directly or indirectly from the operations of all parking facilities being built, renovated, owned, and operated by AHS as security for these debentures.

The maturity dates and interest rates for the debentures are as follows:

	Maturity Date	Fixed Interest Rate
Parkade loan #1	September 2026	4.4025%
Parkade loan #2	September 2027	4.3870%
Parkade loan #3	March 2029	4.9150%
Parkade loan #4	September 2031	4.9250%
Parkade loan #5	June 2032	4.2280%
Parkade loan #6	December 2035	3.6090%

At March 31, 2015, $5,000 of $25,300 has been advanced to AHS relating to the Parkade loan #6 debenture with the remainder to be drawn by December 16, 2015. Semi-annual principal and interest payments of $893 will commence June 16, 2016. See Note 21 for future payments relating to the remaining advances of this loan.

(b) The leased tangible capital assets include a site lease with the University of Calgary and vehicle leases.

The University of Calgary lease expires January 2028. The implicit interest rate payable on this lease is 6.50% (2014 - 6.50%). There are no renewal options, purchase options or escalation clauses related to this leased tangible capital asset.

AHS is contractually committed to future capital lease payments for vehicles until 2020. The implicit interest rate payable on these leases is 1.60% (2014 - 2.08%).

(c) As at March 31, 2015 AHS holds a $220,000 (March 31, 2014 - $220,000) revolving demand facility with a Canadian chartered bank which may be used for operating purposes. Draws on the facility bear interest at the bank's prime rate less 0.50% per annum. As at March 31, 2015, AHS has $nil (March 31, 2014 - $nil) draws against this facility.

AHS also holds a $33,000 (March 31, 2014 - $33,000) revolving demand letter of credit facility which may be used to secure AHS' obligations to third parties relating to construction projects. At March 31, 2015, AHS has $3,100 (March 31, 2014 - $3,310) in letters of credit outstanding against this facility.

Note 18 Debt (continued)

AHS is committed to making payments as follows:

Year ended March 31	Debentures Payable, Term/Other Loan and Mortgages Payable Principal payments	Leased Tangible Capital Assets Minimum lease payments
2016	$ 15,221	$ 3,824
2017	15,942	2,475
2018	16,698	2,099
2019	17,490	1,842
2020	18,319	1,727
Thereafter	238,165	12,329
	$ 321,835	24,296
Less: interest		(6,734)
		$ 17,562

During the year, the amount of interest expensed was $16,253 (2014 - $16,984), of which loan interest was $15,366 (2014 - $16,054) and other interest charges were $887 (2014 - $930).

Note 19 Accumulated Surplus

Accumulated surplus is comprised of the following:

	Unrestricted net assets [a]	Reserves for future purposes [b]	Net assets invested in tangible capital assets [c]	Accumulated surplus
Balance as at April 1, 2014	$ 266,295	$ 87,269	$ 880,241	$ 1,233,805
Operating deficit	(2,504)	-	-	(2,504)
Tangible capital assets purchased with internal funds	(113,974)	-	113,974	-
Amortization of internally funded tangible capital assets	206,087	-	(206,087)	-
Repayment of debt used to fund tangible capital assets	(15,764)	-	15,764	-
Net receipt of life lease deposits	(192)	-	192	-
Transfer of reserves for future purposes	(67,631)	67,631	-	-
Balance as at March 31, 2015	$ 272,317	$ 154,900	$ 804,084	$ 1,231,301

(a) Unrestricted Net Assets

Unrestricted net assets represents the portion of accumulated surplus that has not already been invested in tangible capital assets or reserved for future purposes.

Note 19 Accumulated Surplus (continued)

(b) Reserves for Future Purposes

The Official Administrator has approved the restriction of net assets for future purposes as follows:

	2015	2014
Parkade infrastructure reserve [(i)]	$ 60,920	$ 50,325
Provincial Clinical Information Systems Initiative [(ii)]	32,000	-
Insurance equity requirements [(iii)]	20,012	-
Cancer research reserve [(iv)]	16,079	15,596
Specific local initiatives reserve [(v)]	15,205	14,142
Future capital purposes [(vi)]	10,000	-
Retail food services infrastructure reserve[(vii)]	684	569
South Health Campus [(viii)]	-	6,637
Reserves for future purposes	$ 154,900	$ 87,269

(i) Restriction of parking services surpluses to establish a parking infrastructure reserve for future major maintenance, upgrades, and construction.
(ii) Restriction of operating net assets related to fund the Provincial Clinical Information Systems Initiative.
(iii) Restriction of operating net assets related to the minimum required equity of the LPIP.
(iv) Restriction of operating net assets to fund cancer research.
(v) Restriction of operating net assets for specific local initiatives as a result of local fundraising.
(vi) Restriction of operating net assets related to future capital purposes.
(vii) Restriction of retail food services surplus to assist with future upgrades, maintenance, equipment, and construction costs for retail food service operations.
(viii) Restriction of operating net assets to assist with funding startup costs for South Health Campus in Calgary.

(c) Net Assets Invested in Tangible Capital Assets

The restriction of net assets is equal to the net book value of internally funded tangible capital assets as these net assets are not available for any other purpose.

Note 20 Endowments

	2015	2014
Balance, beginning of year	$ 68,796	$ 65,207
Endowment contributions	3,585	3,589
Balance, end of year	$ 72,381	$ 68,796

Note 21 Contractual Obligations and Contingent Liabilities

Contractual obligations are AHS' obligations to others that will become liabilities in the future when the terms of current or existing contracts or agreements are met.

Note 21 Contractual Obligations and Contingent Liabilities (continued)

(a) Leases

(i) Operating leases:

AHS is contractually committed to future operating lease payments for premises as follows:

Year ended March 31		Total lease payments
2016	$	53,414
2017		48,635
2018		41,376
2019		26,287
2020		19,884
Thereafter		64,917
	$	254,513

(ii) Capital leases:

During the year, AHS entered into a new premises lease with a lease term of 20 years, and an option to renew for two terms of 5 years each. The premises will be ready to occupy in October 2015 at monthly rate of $90 and includes escalation clauses.

The future payments relating to the new lease are as follows:

Year ended March 31		Minimum lease payments
2016	$	568
2017		1,107
2018		1,069
2019		1,033
2020		998
Thereafter		12,591
	$	17,366

(b) Debentures payable

The future payments relating to remaining advances of $20,300 for Parkade loan #6 (Note 18) are as follows:

Year ended March 31		Principal payments
2016	$	-
2017		882
2018		914
2019		947
2020		982
Thereafter		16,575
	$	20,300

Note 21 Contractual Obligations and Contingent Liabilities (continued)

(c) Tangible Capital Assets

AHS has the following outstanding contractual commitments for purchases of tangible capital assets:

		2015
Facilities and improvements	$	87,244
Equipment		40,150
Information systems		7,289
	$	134,683

AI also records contractual commitments for the purchase of tangible capital assets for AHS. The commitments disclosed above do not include the commitments of AI for the construction of AHS facilities.

(d) Contracted Health Service Providers

AHS contracts on an ongoing basis with voluntary and private health service providers to provide health services in Alberta as disclosed in Note 9. AHS has contracted for services in the year ending March 31, 2016 similar to those provided by these providers in 2014-15.

(e) Contingent Liabilities

AHS is subject to legal claims during its normal course of business. AHS records a liability when the assessment of a claim indicates that a future event is likely to confirm that an asset had been impaired or a liability incurred at the date of the financial statements and the amount of the contingent loss can be reasonably estimated.

Accruals have been made in specific instances where it is likely that losses will be incurred based on a reasonable estimate. As at March 31, 2015, accruals have been recorded as part of the provision for unpaid claims (Note 15). Included in this accrual are claims in which AHS has been jointly named with the Minister. The accrual provided for these claims under the provision for unpaid claims represents AHS' portion of the liability.

AHS has been named in 182 legal claims (2014 - 204 claims) related to conditions in existence at March 31, 2015 where the occurrence of a future event confirming a contingent loss is not reasonably determinable. Of these, 160 claims have $283,332 in specified amounts and 22 have no specified amounts (2014 - 172 claims with $321,813 of specified claims and 32 claims with no specified amounts). The resolution of indeterminable claims may result in a liability, if any, that may be different than the claimed amount.

AHS has been named as a co-defendant, along with the GOA, in a certified Class Action (the Claim) arising from increases to long-term accommodation charges implemented by Alberta Government regulations enacted on and after August 1, 2003, and paid by residents of long-term care facilities. The amount of the Claim has not yet been specified.

Note 22 Related Parties

Transactions with the following related parties are considered to be in the normal course of operations. Amounts due to or from the related parties and the recorded amounts of the transactions are included within these consolidated financial statements, unless otherwise stated.

The Minister controls AHS through the appointment of the Official Administrator. The viability of AHS' operations depends on transfers from the Ministry. Transactions between AHS and AH are reported and disclosed in the Consolidated Statement of Operations, the Consolidated Statement of Financial Position, and the Notes to the Consolidated Financial Statements, and are therefore excluded from the table below.

Related parties also include key management personnel of AHS. Related party transactions with key management personnel primarily consist of compensation related payments to employees and senior management and are considered to be in normal course of business. No other material related party transactions were identified for the year ended March 31, 2015.

Note 22 Related Parties (continued)

AHS shares a common relationship and is considered to be a related party with those entities consolidated or included on a modified equity basis in the GOA consolidated financial statements. Transactions in the normal course of operations between AHS and the other ministries are recorded at their exchange amount as follows:

	Revenue [i]		Expenses	
	2015	2014	2015	2014
Ministry of Innovation and Advanced Education [ii]	$ 61,789	$ 60,969	$ 131,866	$ 125,350
Ministry of Infrastructure [iii]	339,484	312,294	309,762	278,441
Other ministries [iv]	56,978	44,909	34,091	32,137
Total for the year	$ 458,251	$ 418,172	$ 475,719	$ 435,928

	Receivable from		Payable to	
	2015	2014	2015	2014
Ministry of Innovation and Advanced Education [ii]	$ 8,014	$ 9,756	$ 18,204	$ 19,196
Ministry of Infrastructure [iii]	9,370	22,234	88	975
Other ministries [iv]	13,764	27,673	325,010	332,938
Balance, end of year	$ 31,148	$ 59,663	$ 343,302	$ 353,109

(i) Revenues with the GOA ministries include other government transfers of $414,442 (2014 - $378,622), (Note 4) and other income of $43,809 (2014 - $39,550), (Note 6).

(ii) Most of AHS transactions with the Ministry of Innovation and Advanced Education relate to initiatives with the University of Alberta and the University of Calgary. These initiatives include teaching, research, and program delivery. A number of physicians are employed by either AHS or the universities but perform services for both. Due to proximity of locations, some initiatives result in sharing physical space and support services. The revenue and expense transactions are a result of grants provided from one to the other and recoveries of shared costs.

(iii) The transactions with the Ministry of Infrastructure relate to the construction and funding of tangible capital assets. These transactions include operating transfers of $31,093 (2014 - $34,188) and capital transfers recognized of $285,261 (2014 - $254,331) relating to tangible capital assets with stipulations or external restrictions to utilize over their remaining useful lives, (Note 4).

Transactions with AI also include the transfer of non-cash work-in-progress of $412,623 (2014 - $270,569) included in total amounts disclosed in Note 14(a).

(iv) The payable transactions with other ministries include the debt payable to ACFA (Note 18(a)).

At March 31, 2015 AHS has recorded deferred revenue from other ministries within the GOA, excluding AH, of $26,404 (March 31, 2014 - $40,545) related to unexpended deferred operating revenue, $9,838 (March 31, 2014 - $38,968) related to unexpended deferred capital revenue and $5,835,000 (March 31, 2014 - $5,678,020) related to expended deferred capital revenue. See Note 17.

Outstanding contingencies in which AHS has been jointly named with other government entities within the GOA are disclosed in Note 21.

Note 23 Government Partnerships

The following is 100% of the financial position and results of operations for AHS' government partnerships with PCNs, NACTRC and HUTV.

	2015	2014
Total assets	$ 160,437	$ 144,819
Total liabilities	160,437	144,819
Net assets	$ -	$ -
Total revenue	$ 201,229	$ 176,398
Total expenses	201,229	176,398
Net operating surplus	$ -	$ -

AHS has proportionately consolidated 50% of the results of the PCNs and NACTRC, and 30% of HUTV.

As required by AH, PCNs can only use accumulated surpluses based on approved surplus utilization; therefore, AHS' proportionate share of these surpluses has been recorded by AHS as deferred revenue.

Note 24 Health Benefit Trust of Alberta (HBTA)

AHS is one of more than 30 participants in the HBTA and has a majority of representation on the HBTA governance board. The HBTA is a formal health and welfare trust established under a Trust Agreement effective January 1, 2000. The HBTA provides health and other related employee benefits pursuant to the authorizing Trust Agreement.

Under the terms of the Trust Agreement, no participating employer or eligible employee shall have any right to any surplus or assets of the Trust nor shall they be responsible for any deficits or liabilities of the Trust.

The HBTA maintains various reserves to adequately provide for all current obligations and reported fund balances of $116,453 as at December 31, 2014 (December 31, 2013 - $102,201). AHS has included in prepaid expenses $85,593 (March 31, 2014 - $74,351) as a share of the HBTA's fund balances representing in substance a prepayment of future contributions. These consolidated financial statements do not include the HBTA other than the premiums paid by AHS. For the period January 1 to December 31, 2014 AHS paid premiums of $290,440 (2013 - $280,586).

Note 25 Trust Funds

AHS receives funds in trust for research and development, education, and other programs. These amounts are held and administered on behalf of others in accordance with the terms and conditions embodied in the relevant agreements with no unilateral power to change the conditions set out in the trust indenture (or agreement) and therefore are not reported in these consolidated financial statements. As at March 31, 2015, the balance of funds held in trust by AHS for research and development is $8,499 (March 31, 2014 - $8,033).

AHS also receives funds in trust from continuing care residents for personal expenses. These amounts are not included above and not consolidated in these financial statements.

Note 26 Corresponding Amounts

Certain 2014 amounts have been reclassified to conform to 2015 presentation.

Note 27 Approval of Consolidated Financial Statements

Upon recommendation by the Audit & Risk Committee, the consolidated financial statements were approved by the Official Administrator on June 4, 2015.

SCHEDULE 1 - CONSOLIDATED SCHEDULE OF EXPENSES BY OBJECT
YEAR ENDED MARCH 31

	2015		2014
	Budget (Note 3)	Actual	Actual (Note 26)
Salaries and benefits (Schedule 2)	$ 7,348,000	$ 7,531,854	$ 7,049,361
Contracts with health service providers (Note 9)	2,354,000	2,375,811	2,258,042
Contracts under the Health Care Protection Act	18,000	19,141	18,918
Drugs and gases	428,000	411,672	400,792
Medical and surgical supplies	404,000	403,626	390,647
Other contracted services	1,152,000	1,137,794	1,089,891
Other [(a)]	1,308,000	1,286,789	1,260,774
Amortization, disposals and write-downs (Note 14)	556,000	633,593	564,926
	$ 13,568,000	$ 13,800,280	$ 13,033,351
(a) Significant amounts included in Other are:			
Equipment expense		$ 181,131	$ 173,960
Other clinical supplies		141,884	141,464
Building rent		124,291	118,495
Utilities		118,766	125,454
Housekeeping, laundry and linen, plant maintenance and biomedical engineering supplies		89,418	88,951
Building and ground expenses		86,388	88,991
Food and dietary supplies		76,144	70,679
Office supplies		62,450	58,894
Fundraising and grants awarded		58,815	45,404
Minor equipment purchases		57,484	78,997
Insurance		48,589	34,323
Telecommunications		44,945	45,446
Travel		43,131	39,337
Licenses, fees and memberships		25,434	19,541
Education		16,026	12,558
Other		111,893	118,280
		$ 1,286,789	$ 1,260,774

SCHEDULE 2 - CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS
FOR THE YEAR ENDED MARCH 31, 2015

	2015								2014	
						Severance and Termination Benefits [e]				
	FTE[a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Number of Individuals	Amount	Total	FTE [a]	Total
Total Official Administrator/Advisory Committees (Sub-Schedule 2A)	8.72	$ 545	$ 191	$ -	$ 736	-	$ -	$ 736	3.59	$ 589
Total Former Board	-	-	-	-	-	-	-	-	2.92	126
Total Executive (Sub-Schedule 2B)	14.57	5,130	246	1,049	6,425	1	196	6,621	15.82	9,984
Management Reporting to CEO Direct Reports	56.27	13,468	128	2,527	16,123	-	-	16,123	30.95	11,329
Other Management	3,303.18	388,924	2,685	84,061	475,670	24	1,160	476,830	3,249.68	471,006
Medical Doctors not included above[f]	165.56	50,135	187	3,387	53,709	1	293	54,002	164.03	53,784
Regulated nurses not included above:										
RNs, Reg. Psych. Nurses, Grad Nurses	18,553.48	1,661,730	304,110	369,355	2,335,195	8	344	2,335,539	18,082.40	2,166,883
LPNs	4,212.33	267,698	34,976	58,823	361,497	1	50	361,547	3,940.43	325,988
Other Health Technical & Professionals	15,530.56	1,325,776	104,206	311,913	1,741,895	21	662	1,742,557	14,859.70	1,631,285
Unregulated Health Service Providers	7,406.48	364,239	48,712	83,401	496,352	3	80	496,432	7,122.45	459,152
Other Staff	26,703.37	1,576,563	102,750	360,864	2,040,177	63	1,290	2,041,467	25,894.06	1,919,235
Total	75,954.52	$ 5,654,208	$ 598,191	$ 1,275,380	$ 7,527,779	122	$ 4,075	$ 7,531,854	73,366.03	$ 7,049,361

The accompanying footnotes and sub-schedules are part of this schedule

SUB-SCHEDULE 2A – OFFICIAL ADMINISTRATOR/ADVISORY COMMITTEES REMUNERATION FOR THE YEAR ENDED MARCH 31, 2015

	Term	2015 Committees	2015 Remuneration	2014 Remuneration
Official Administrator				
Dr. Carl Amrhein	Since Nov 17, 2014	AFAC, ARC, FC, HRAC, QSAC	$ 186	$ -
Janet Davidson	Jun 12, 2013 to Sep 9, 2013; Sep 10, 2014 to Nov 16, 2014	AFAC, HRAC, QSAC	119	166
Dr. John Cowell	Sep 10, 2013 to Sep 9, 2014	AFAC, HRAC, QSAC	295	372
Advisory Committee Participants[g]				
Barbara Burton	Since Dec 11, 2013	HRAC (Chair)	6	2
Phyllis Clark	Oct 21, 2013 to Dec 4, 2013	-	-	1
Dr. Thomas Feasby	Since Jan 21, 2014	QSAC	2	1
Martin Harvey	Since Dec 11, 2013	HRAC	2	2
Gregory Henders	Dec 11, 2013 to Feb 13, 2015	HRAC	2	2
Brian Olson	Sep 24, 2013 to Jan 31, 2015	AFAC, HRAC (Chair), QSAC	33	12
Don Sieben	Since Sep 25, 2013	AFAC (Chair), ARC (Chair), FC (Chair), HRAC, QSAC	44	19
Doug Tupper	Since Nov 28, 2013	AFAC, ARC, FC, HRAC, QSAC (Chair)	44	11
Gord Winkel	Since Jan 21, 2014	QSAC	3	1
Total Official Administrator/Advisory Committees			$ 736	$ 589

Dr. Carl Amrhein was appointed to the position of Official Administrator effective November 17, 2014 (calculated FTE of 0.37) as per Ministerial Order 314/2014 to a term set to expire June 30, 2015. The incumbent is on secondment from the University of Alberta. AHS reimburses the University for the incumbent's base salary and benefits including annual performance adjustments. Remuneration is not to exceed $330 for the term.

Janet Davidson was re-appointed to the position of Official Administrator effective September 10, 2014 (calculated FTE of 0.18) as per Ministerial Order 310/2014 until November 16, 2014. AHS reimbursed AH for the incumbent's base salary and benefits. Remuneration was $580 per annum plus benefits.

Dr. John Cowell held the position of Official Administrator until September 9, 2014 (calculated FTE of 0.45) at which time his term expired. Remuneration was $580 per annum plus $87 per annum in lieu of benefits.

Advisory committees were established by the Official Administrator to aid in governing AHS and overseeing the management of AHS' business and affairs. On June 4, 2014, the Quality Assurance and Patient Safety Advisory Committee was renamed as the Quality and Safety Advisory Committee. On February 10, 2015, the Audit and Finance Advisory Committee was divided into the Audit and Risk Committee and Finance Committee. Advisory committee participants are eligible to receive honoraria for meetings attended. Advisory committee chairs are compensated an additional $30 per annum.

Committee legend: AFAC = Audit and Finance Advisory Committee, ARC = Audit and Risk Committee. FC = Finance Committee, HRAC = Human Resources Advisory Committee, QSAC = Quality and Safety Advisory Committee

SUB-SCHEDULE 2B - EXECUTIVE SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2015

For the Current Fiscal Year	2015						
	FTE [a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Severance and Termination Benefits [e]	Total
Official Administrator Direct Reports							
Vickie Kaminski – President and Chief Executive Officer [h,ff]	0.85	$ 459	$ -	$ 82	$ 541	$ -	$ 541
Brenda Huband – Interim President and Chief Executive Officer, Zone and Health Operations [i,gg]	0.15	60	-	11	71	-	71
Rick Trimp – Interim President and Chief Executive Officer Population Heath and Province-Wide Services [j,kk]	0.15	60	-	8	68	-	68
Dr. Chris Eagle – Special Advisor [k,kk]	0.34	195	83	75	353	-	353
Ronda White – Chief Audit Executive [l,hh]	1.00	237	2	53	292	-	292
Catherine MacNeill – Acting Corporate Secretary [m]	0.50	92	-	18	110	-	110
Kristin Long – Corporate Secretary [n]	0.16	32	-	23	55	-	55
David Diamond – Chief External Relations Officer [o,kk]	0.61	196	12	35	243	-	243
CEO Direct Reports							
Brenda Huband – VP and Chief Health Operations Officer, Central and Southern Alberta [i,gg]	0.85	315	-	64	379	-	379
Dr. Francois Belanger – VP and Medical Director, Central and Southern Alberta [p,gg]	1.00	455	-	139	594	-	594
Deb Gordon – VP and Chief Health Operations Officer, Northern Alberta [q,gg]	1.00	371	-	79	450	-	450
Dr. David Mador – VP and Medical Director, Northern Alberta [r,ii]	1.00	455	-	91	546	-	546
Linda Dempster – VP Collaborative Practice, Nursing and Health Professions [s,gg]	0.02	5	-	2	7	-	7
Dr. Verna Yiu – VP, Quality and Chief Medical Officer [t,u,jj]	1.00	548	35	33	616	-	616
Rick Trimp – VP, Province-Wide Clinical Supports, Programs and Services [j,kk]	0.44	163	30	24	217	196	413
Mauro Chies – Acting VP, Province-Wide Clinical Supports, Programs and Services [v]	0.15	35	8	7	50	-	50
Dr. Kathryn Todd – VP, Research, Innovation and Analytics [t,w,jj]	1.00	278	10	28	316	-	316

SUB-SCHEDULE 2B - EXECUTIVE SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2015 (CONTINUED)

For the Current Fiscal Year	2015						
	FTE [a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Severance and Termination Benefits [e]	Total
CEO Direct Reports (continued)							
Robert Armstrong – Acting VP, Human Resources [z,gg]	0.75	$ 184	$ 26	$ 41	$ 251	$ -	$ 251
Susan McGillivray – Acting VP, People [y]	0.25	62	8	11	81	-	81
Carmel Turpin – VP, Community Engagement and Communications [z,gg]	0.41	119	-	31	150	-	150
Colleen Turner – Acting VP, Community Engagement and Communications [aa]	0.59	139	14	35	188	-	188
Deborah Rhodes – VP Corporate Services and Chief Financial Officer [bb,gg]	1.00	360	18	79	457	-	457
Noela Inions – Chief Ethics and Compliance Officer [cc,gg]	1.00	226	-	55	281	-	281
Salimah Walji-Shivji – General Counsel, Legal and Privacy [dd,gg]	0.35	84	-	25	109	-	109
Total Executive	14.57	$ 5,130	$ 246	$ 1,049	$ 6,425	$ 196	6,621

SUB-SCHEDULE 2B - EXECUTIVE SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2015 (CONTINUED)

For the Prior Fiscal Year	2014						
	FTE [a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Severance and Termination Benefits [e]	Total
Board/Official Administrator Direct Reports							
Vickie Kaminski – President and Chief Executive Officer	-	$ -	$ -	$ -	$ -	$ -	$ -
Brenda Huband – Interim President and Chief Executive Officer, Zone and Health Operations	0.37	148	-	28	176	-	176
Rick Trimp – Interim President and Chief Executive Officer Population Heath and Province-Wide Services	0.37	148	-	29	177	-	177
Duncan Campbell – Acting President and Chief Executive Officer	0.09	33	5	5	43		43
Dr. Chris Eagle – President and Chief Executive Officer	0.54	316	8	31	355	-	355
Dr. Chris Eagle – Special Advisor	0.46	264	6	26	296	-	296
Ronda White – Chief Audit Executive	1.00	233	16	42	291	-	291
Noela Inions – Chief Ethics and Compliance Officer	1.00	226	-	49	275	-	275
Kristin Long – Corporate Secretary	0.75	125	2	11	138	-	138
Patti Grier – Chief of Staff and Corporate Secretary	0.38	74	28	11	113	-	113
David Diamond – Chief External Relations Officer	0.50	161	-	19	180	-	180
CEO Direct Reports							
Duncan Campbell – VP Corporate Services and Chief Financial Officer [ee]	0.91	392	20	62	474	523	997
Deborah Rhodes – Acting VP Corporate Services and Chief Financial Officer	0.48	168	16	30	214	-	214
Brenda Huband – VP and Chief Health Operations Officer, Central and Southern Alberta	0.18	67	-	14	81	-	81
Dr. Francois Belanger – VP and Medical Director, Central and Southern Alberta	0.56	185	64	28	277	-	277
Deb Gordon – VP and Chief Health Operations Officer, Northern Alberta	0.21	78	-	10	88	-	88
Deb Gordon – VP Collaborative Practice, Nursing and Health Professions	0.79	276	-	36	312	-	312
Dr. Tom Noseworthy – Acting VP and Chief Health Operations Officer, Northern Alberta	0.35	105	60	-	165	-	165
Dr. David Mador – VP and Medical Director, Northern Alberta	0.56	186	54	36	276	-	276

SUB-SCHEDULE 2B - EXECUTIVE SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2015 (CONTINUED)

For the Prior Fiscal Year	2014						
	FTE [a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Severance and Termination Benefits [e]	Total
CEO Direct Reports (continued)							
Dr. Verna Yiu – VP, Quality and Chief Medical Officer	1.00	$ 495	$ 58	$ 32	$ 585	$ -	$ 585
Rick Trimp – VP, Province-Wide Clinical Supports, Programs and Services	0.18	67	16	14	97	-	97
Mauro Chies – Acting VP, Province-Wide Clinical Supports, Programs and Services	0.56	129	25	24	178	-	178
Susan McGillivray – Acting VP, People	0.43	107	14	13	134	-	134
Mark Haley – VP, People	0.11	76	-	-	76	-	76
Colleen Turner – Acting VP, Community Engagement and Communications	0.56	131	13	23	167	-	167
Dr. Kathryn Todd – VP, Research, Innovation and Analytics	1.00	250	10	26	286	-	286
Chris Mazurkewich – Former Executive VP and Chief Operating Officer	0.45	211	127	25	363	541	904
Dr. David Megran – Former Executive VP and Chief Medical Officer, Clinical Operations	0.45	215	83	144	442	730	1,172
Stephen Gould – Former Executive VP, People and Partners	0.48	198	66	24	288	337	625
Bill Trafford – Acting VP and Chief Transition Officer	0.65	222	44	27	293	391	684
Barbara Pitts – Former Senior VP, Priorities and Performance	0.45	166	22	10	198	424	622
Total Executive	15.82	$ 5,452	$ 757	$ 829	$ 7,038	$ 2,946	$ 9,984

SUB-SCHEDULE 2C - EXECUTIVE SUPPLEMENTAL PENSION PLAN AND SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN

Certain employees will receive retirement benefits that supplement the benefits limited under the registered plans for service post 1991. The Supplemental Pension Plan (SPP) is a defined contribution plan and the Supplemental Executive Retirement Plan (SERP) is a defined benefit plan. The SERP is disclosed in Notes 2(g)(iii) and 16(d). The amounts in this table represent the total SPP and SERP benefits earned by the individual during the fiscal year. The current period benefit costs for SPP and the current period benefit costs and other costs for SERP included in other non-cash benefits disclosed in Sub-Schedule 2B are prorated for the period of time the individual was in their position directly reporting to the Official Administrator and directly reporting to the President and Chief Executive Officer. Only individuals holding a position directly reporting to either the Official Administrator or President and Chief Executive Officer during the current fiscal year are disclosed.

	2015			2014			
	SPP	SERP					
	Current period benefit costs[1]	Other Costs[2]	Total	Total	Account Balance[3] or Accrued Benefit Obligation March 31, 2014	Change During the Year[4]	Account Balance[3] or Accrued Benefit Obligation March 31, 2015
Vickie Kaminski - President and Chief Executive Officer	$ 39	$ -	$ 39	$ -	$ -	$ 39	$ 39
Brenda Huband - Interim President and Chief Executive Officer, Zone and Health Operations/VP and Chief Health Operations Officer, Central and Southern Alberta							
- SERP	-	9	9	(1)	396	16	412
- SPP	26	-	26	23	39	28	67
Rick Trimp - Interim President and Chief Executive Officer, Population Heath and Province-Wide Services/VP, Province-Wide Clinical Supports, Programs and Services	16	-	16	23	27	(27)	-
Dr. Chris Eagle - Special Advisor							
- SERP	-	39	39	(5)	1,768	(4)	1,764
- SPP	28	-	28	45	146	(36)	110
Ronda White - Chief Audit Executive	10	-	10	9	27	12	39
Catherine MacNeill - Acting Corporate Secretary	3	-	3	2	2	3	5
Kristin Long - Corporate Secretary	1	-	1	1	1	1	2
David Diamond - Chief External Relations Officer							
- SERP	-	5	5	(5)	226	(226)	-
- SPP	12	-	12	18	33	(33)	-
Dr. Francois Belanger - VP and Medical Director, Central and Southern Alberta	50	-	50	19	37	52	89
Deb Gordon - VP and Chief Health Operations Officer, Northern Alberta							
- SERP	-	14	14	(14)	611	(1)	610
- SPP	26	-	26	22	30	27	57
Dr. David Mador - VP and Medical Director, Northern Alberta	48	-	48	20	20	49	69

SUB-SCHEDULE 2C - EXECUTIVE SUPPLEMENTAL PENSION PLAN AND SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN (CONTINUED)

	2015			2014			
	SPP	SERP					
	Current period benefit costs[1]	Other Costs[2]	Total	Total	Account Balance[3] or Accrued Benefit Obligation March 31, 2014	Change During the Year[4]	Account Balance[3] or Accrued Benefit Obligation March 31, 2015
Linda Dempster - VP Collaborative Practice, Nursing and Health Professions	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dr. Verna Yiu - VP, Quality and Chief Medical Officer [5]	-	-	-	-	-	-	-
Mauro Chies - Acting VP, Province-Wide Clinical Supports, Programs and Services	11	-	11	8	23	13	36
Dr. Kathryn Todd - VP, Research, Innovation and Analytics [5]	-	-	-	-	-	-	-
Robert Armstrong - Acting VP, Human Resources	11	-	11	10	15	11	26
Susan McGillivray - Acting VP, People							
- SERP	-	3	3	(3)	128	-	128
- SPP	11	-	11	11	17	12	29
Carmel Turpin - VP, Community Engagement and Communications	7	-	7	-	-	7	7
Colleen Turner - Acting VP, Community Engagement and Communications	10	-	10	9	25	12	37
Deborah Rhodes - VP Corporate Services and Chief Financial Officer	25	-	25	21	77	31	108
Noela Inions - Chief Ethics and Compliance Officer	8	-	8	8	42	12	54
Salimah Walji-Shivji - General Counsel, Legal and Privacy	6	-	6	5	18	8	26

(1) The SPP current period benefit costs are AHS contributions earned in the period.
(2) Other SERP costs include retirement benefits, interest expense on the obligations, and amortization of actuarial gains and losses, offset by the expected return on the plans' assets.
(3) The account balance represents the total cumulative earned contributions to the SPP as well as cumulative investment gains or losses on the contributions.
(4) Changes in the accrued benefit obligation include current period benefit cost, interest accruing on the obligations and the amortization of any actuarial gains or losses in the period. Changes in the account balance include the current benefit costs and investment gains or losses related to the account.

FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS
FOR THE YEAR ENDED MARCH 31, 2015

Definitions

a. For this schedule, Full time equivalents (FTE) are determined by actual hours earned divided by 2,022.75 annual base hours. FTE for the Official Administrator and Advisory Committee members are prorated using the number of days in the fiscal year between either the date of appointment and the end of the year, the date of appointment and the termination date, or the beginning of the year and the termination date.

b. Base salary is regular salary and includes all payments earned related to actual hours earned other than those reported as other cash benefits.

Vacation accruals are included in base salary except for direct reports of the Official Administrator or President and Chief Executive Officer whose vacation payouts are included in other cash benefits and vacation accruals are included in other non-cash benefits.

c. Other cash benefits may include as applicable honoraria, overtime, acting pay, lump sum payments and an allowance for professional development. Market supplements and automobile allowances were also included in the prior year, however, they are no longer applicable for the current year. Relocation expenses are excluded from compensation disclosure as they are considered to be recruiting costs to AHS and not part of compensation unless related to severance or termination benefits. Expense reimbursements are also excluded from compensation disclosure except where the expenses meet the definition of the other cash benefits listed above.

d. Other non-cash benefits include:
- Employer's current period benefit costs and other costs of supplemental pension plan and supplemental executive retirement plans as defined in Sub-Schedule 2C
- Employer's share of employee benefit contributions and payments made on behalf of employees including pension, health care, dental and vision coverage, out-of-country medical benefits, group life insurance, accidental disability and dismemberment insurance, and long and short-term disability plans, and
- Employer's share of the cost of additional benefits including sabbaticals or other special leave with pay.

e. Severance and termination benefits include direct or indirect payments to individuals upon termination or through a voluntary exit program which are not included in other cash benefits or other non-cash benefits.

f. Compensation for medical doctors included in salaries and benefits expense includes medical doctors paid through AHS payroll. The compensation for the remaining medical doctors is included in other contracted services.

FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2015 (CONTINUED)

Official Administrators and Advisory Committee Participants

g. These individuals are participants of Official Administrator governance advisory committees, but are not AHS employees.

Executive

h. The incumbent held the position effective May 26, 2014. The contract term ends May 26, 2017.

i. The incumbent held the dual positions of Interim President and Chief Executive Officer, Zone and Health Operations and Vice President and Chief Health Operations Officer, Central and Southern Alberta until May 26, 2014 at which time the incumbent resumed solely the role of Vice President and Chief Health Operations Officer, Central and Southern Alberta along with a return to the annual compensation commensurate of the position.

j. The incumbent held the dual positions of Interim President and Chief Executive Officer, Population Health and Province-Wide Services and Vice President, Province-Wide Clinical Supports, Programs and Services until May 26, 2014 at which time the incumbent resumed solely the role of Vice President, Province-Wide Clinical Supports, Programs and Services along with a return to the annual compensation commensurate of the position. The incumbent held the position until October 31, 2014 at which time the incumbent left AHS. The incumbent received the salary and other accrued entitlements to the date of departure. The reported severance included 24 weeks base salary at the rate in effect at the date of departure and 15% of the severance in lieu of benefits. AHS will also make payments for the incumbent to attend an outplacement program for a maximum of 6 months.

k. The incumbent held the position until October 19, 2014 at which time the incumbent left AHS. The incumbent took a sabbatical leave from August 5, 2014 to October 17, 2014; this time is not included in the incumbent's calculated FTE.

l. In addition to the position of Chief Audit Executive, the incumbent was assigned to the acting lead role for Legal and Privacy and received acting pay until April 25, 2014.

m. The incumbent held the position of Legal Counsel - Corporate/Commercial until May 26, 2014 at which time the incumbent was appointed to Acting Corporate Secretary and became a direct report to the Official Administrator. As a result of restructuring, the incumbent ceased to be a direct report to the Official Administrator effective November 24, 2014.

n. The incumbent began a leave of absence on May 29, 2014. As a result of restructuring, the incumbent ceased to be a direct report to the Official Administrator effective November 24, 2014.

o. The incumbent held the position until November 9, 2014 at which time the incumbent left AHS.

p. A Senior Medical Leadership compensation review for the incumbent was finalized June 20, 2014. As a result, the incumbent's annual compensation was adjusted retroactive to April 1, 2013. An increase in the incumbent's base salary was offset by a retroactive elimination of the incumbent's market supplement. The net retroactive adjustment of $5 per annum is reflected in the current year base salary amount.

FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2015 (CONTINUED)

q. The incumbent held the dual positions of Vice President and Chief Health Operations Officer, Northern Alberta and Acting Vice President Collaborative Practice, Nursing and Health Professions until March 25, 2015 at which time the incumbent began transitioning out of the role of Acting Vice President Collaborative Practice, Nursing and Health Professions while retaining solely the role of Vice President and Chief Health Operations Officer, Northern Alberta.

r. A Senior Medical Leadership compensation review for the incumbent was finalized June 20, 2014. As a result, the incumbent's annual compensation was adjusted retroactive to April 1, 2013. An increase in the incumbent's base salary was offset by a retroactive elimination of the incumbent's market supplement. The net retroactive adjustment of $5 per annum is reflected in the current year base salary amount.

s. The incumbent was appointed to the position effective March 25, 2015.

t. The incumbent is on secondment from the University of Alberta. The incumbent's total remuneration is comprised of salary amounts from both AHS and the University of Alberta. AHS reimburses the University for the incumbent's base salary and benefits including annual performance adjustments. In lieu of enrollment into the AHS SPP, the incumbent will receive an annual lump sum supplemental payment equivalent to the amount the incumbent would have received as a member of the SPP and payable from AHS. The lump sum has been included in Other Cash Benefits.

u. A Senior Medical Leadership compensation review for the incumbent was finalized July 17, 2014. As a result, the incumbent's annual compensation was adjusted retroactive to April 1, 2013. The retroactive adjustment of $27 per annum is reflected in the current year base salary amount.

v. The incumbent held the position of Acting Vice President, Province-Wide Clinical Supports, Programs & Services and received acting pay until May 26, 2014 at which time the incumbent resumed the role of Chief Program Officer, Clinical Support Services and was no longer a direct report to the President and Chief Executive Officer.

w. A Senior Leadership compensation review for the incumbent was finalized July 16, 2014. As a result, the incumbent's annual compensation was adjusted retroactive to April 1, 2013. The retroactive adjustment of $14 per annum is reflected in the current year base salary amount.

x. The incumbent held the position of Senior Program Officer, HR Shared Services, Workforce Strategies and Total Rewards until June 30, 2014 at which time the incumbent was appointed to Acting Vice President, Human Resources and became a direct report to the President and Chief Executive Officer. The incumbent received acting pay while in the Acting Vice President, Human Resources position.

y. The incumbent held the position of Acting Vice President, People and received acting pay until June 27, 2014 at which time the incumbent resumed the role of Senior Program Officer, HR Client Services and Employee/Labour Relations and was no longer a direct report to the President and Chief Executive Officer.

z. The incumbent was appointed to the position effective November 3, 2014.

aa. The incumbent held the position of Acting Vice President Community Engagement and Communications and received acting pay until November 3, 2014 at which time the incumbent resumed the role of Senior Program Officer, Communications and was no longer a direct report to the President and Chief Executive Officer.

FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2015 (CONTINUED)

bb. The incumbent held the position of Acting Vice President Corporate Services and Chief Financial Officer and received acting pay until September 29, 2014 when the incumbent was appointed to the position of Vice President Corporate Services and Chief Financial Officer. The incumbent received an increase in compensation for the new position.

cc. As a result of restructuring, the incumbent's position changed from a direct reporting position to the Official Administrator to a direct reporting position to the President and Chief Executive Officer effective November 17, 2014.

dd. The incumbent held the position of Acting General Counsel until November 24, 2014 at which time the incumbent was appointed to General Counsel, Legal and Privacy and became a direct report to the President and Chief Executive Officer. The incumbent received an increase in compensation for the new position.

ee. In the prior year, reimbursement of relocation expenses of $43 was accrued for the incumbent. However the relocation expenses reimbursed to the incumbent totalled $23. The prior year balance has been restated to reflect the actual relocation expenses reimbursed.

Termination Liabilities

ff. In the case of termination without just cause by AHS, the incumbent shall receive severance pay equal to one month annual base salary for each completed month of service to a maximum of twelve months. Monthly severance payments will be reduced by the amount of any employment income or consulting earnings received from a new employer during the month.

gg. The incumbent's termination benefits have not been predetermined.

hh. In the case of termination without just cause by AHS, the incumbent shall receive severance pay equal to 12 months base salary. The severance payment will be reduced by any employment earnings received from a new employer within the 12 month period.

ii. In the case of termination without just cause by AHS, the incumbent shall receive severance pay to a maximum of 12 months base salary plus market supplement. Such severance will be paid in 12 equal monthly installments. The severance payment will be reduced by any employment earnings received from a new employer within the 12 month period.

jj. There is no severance associated with the secondment agreement. Upon termination of the secondment agreement, the incumbent would return to the incumbent's regular position at the University of Alberta.

FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2015 (CONTINUED)

kk. SPP and SERP

Based on the provision of the applicable SPP and SERP, the following outlines the benefits received by individuals who terminated employment with AHS within the 2014-15 fiscal period. As a result of retirement or termination, the incumbents are entitled to the benefits accrued to them up to the date of retirement or termination. For participants of SPP, the benefit includes the account balances as at March 31, 2015 and the current period benefit costs and investment gains or losses related to the account that were incurred during the current year. For participants of SERP, the benefit includes the accrued benefit obligation as at March 31, 2015, the current period benefit cost, interest accruing on the obligations, and the amortization of any actuarial gains or losses in the period that were incurred during the current year as identified in Sub-Schedule 2C. The AHS obligations are paid through either a lump sum payment or regular instalments:

Position	Supplemental Plan Commencement Date	Benefit (not in thousands)	Frequency	Payment Terms
Special Advisor (SPP)	April 1, 2011	$36,682 increasing annually to $37,048	Annually	For a fixed term of 5 years from November 2014 to January 2018
Special Advisor (SERP)	January 1, 2003	$15,222	Monthly	For a fixed term of 10 years from November 1, 2014 to October 1, 2024
Interim President and Chief Executive Officer, Population Heath and Province Wide Services/VP, Province-Wide Clinical Supports, Programs and Services (SPP)	December 3, 2012	$21,928 $21,958	Twice	November 2014 January 2015
Chief External Relations Officer (SPP)	May 1, 2012	$46,921	Once	January 2015
Chief External Relations Officer (SERP)	November 10, 2006	$191,013	Once	December 2014

COMPENSATION ANALYSIS AND DISCUSSION

A total compensation strategy is the blueprint for creating an organization's total compensation program. It includes the mix of direct and indirect compensation to be provided to employees and the means through which it will be provided in order to support an organization's goals. It is important that total compensation in a publicly funded organization such as Alberta Health Services (AHS) has a governance approved strategy or "blueprint" that is properly aligned with its direction, goals and values.

Total Compensation Philosophy

AHS reinforces outstanding patient care for all Albertans by attracting, retaining and engaging talented and committed employees. We do this with competitive and fair total compensation that motivates and rewards performance while demonstrating sound fiscal management and sustainability. Principles set out in the total compensation policy guided AHS' total compensation philosophy. It reflects:

- competitive market positioning
- internal equity
- performance orientation
- affordability
- individual flexibility
- shared employee/employer responsibility

Total Compensation Strategy

AHS ensures the process used to set total compensation, establish and maintain good governance and incorporate best practices is transparent. The job rates for Executive and Senior Leadership salary ranges *are representative of the median of the national health care and Alberta public sector market – there are no private sector comparators.* To ensure total compensation remains market competitive, AHS reviews its market positioning on a regular basis and in any event, no less than once every second year. Salary ranges are published on the AHS website.

AHS' Total Compensation programs and practices encourage behaviours that will promote a patient-focused, quality health system that is accessible and sustainable for all Albertans.

Total Compensation Plan Structure

AHS is committed to providing a comprehensive total compensation package including salary, benefits, pension and other programs and services that support attracting, retaining and engaging talented and committed employees. AHS' total compensation is comprised of direct and indirect compensation. Elements within direct and indirect compensation fit the overall total compensation strategy by driving accountability and performance, demonstrating sound fiscal management, and promoting a sense of integrity and equity.

Total Compensation represents all the advantages of working for AHS from the pay employees receive, to benefit packages and recognition for a job well done.

The plan is designed to attract, retain and motivate employees to deliver quality, patient-focused health care for all Albertans.

Direct Compensation includes pay received as wages, salaries, overtime and premiums provided at regular and consistent intervals. It integrates with the AHS Performance Management Program. AHS has no incentive, variable pay or pay at risk of any kind.

Base salary ranges are intended to be competitive compared to the median (50th percentile) of the national health care market and the Alberta public sector market. An employee's individual base salary is set based on individual performance and salary range adjustments within AHS market comparators. Human Resources Advisory Committee (HRAC) reviews and approves base salaries for the executive leadership team annually.

Indirect Compensation includes benefits and pension (including supplemental pension plan), terms and conditions, and employee appreciation. AHS' benefits and pension plans support the health and well-being of our employees and financial security upon retirement.

AHS provides a competitive benefits program that includes pension, health and dental-care benefits, life insurance, illness and long-term disability coverage and professional memberships.

All AHS employees participate in the Local Authorities Pension Plan (LAPP). This is a defined benefit pension plan. It provides for a pension of 1.4 per cent for each year of pensionable service based on the average salary of the highest 5 consecutive years up to the Year's Maximum Pensionable Earnings under the Canada Pension Plan and 2.0 per cent on the excess. Benefits under this plan are capped at the maximum pension benefit limit allowed under the federal *Income Tax Act*, a salary of $154,250 in 2014.

As pensionable earnings are limited under LAPP, AHS provides a Supplemental Pension Plan (SPP). Unlike the Local Authorities Pension, the SPP is a Defined Contribution plan that provides annual notional contributions that are allocated to and invested as directed by each member. The SPP was created to be fiscally sustainable as it replaced the more expensive legacy Supplemental Executive Retirement Plans (SERPs). The SPP allows AHS to maintain a competitive position, but at less cost and risk to the organization.

AHS does not provide car allowances or perquisite allowances to its executives or employees. These practices were discontinued by fiscal 2014-15.

Total Compensation Governance

The HRAC monitors, oversees and advises the Official Administrator on total compensation matters related to AHS including:

- determining the overall strategic approach to compensation
- reviewing substantive changes to total compensation programs to ensure they support the organization's mission, strategic directions and values
- approving the compensation of the President & Chief Executive Officer (CEO) and Vice Presidents
- approving the compensation philosophy recommended by the President & CEO for non-executive staff of AHS

Total Compensation Reporting

The Schedule 2 – Consolidated Schedule of Salaries and Benefits in the annual audited consolidated financial statements for the year ended March 31, 2015 provides complete disclosure of salary, benefits, and all other compensation earned for years ended March 31, 2015 and March 31, 2014 by the direct reports to the Official Administrator and direct reports to the President & CEO. The Official Administrator's compensation is disclosed in Schedule 2 – Consolidated Schedule of Salaries and Benefits in the annual audited consolidated financial statements for the year ended March 31, 2015.

Information on total compensation philosophy and practices can be found on the AHS website www.albertahealthservices.ca/204.asp.

APPENDIX

- Partner Foundations & Health Trusts
- Health Quality Council of Alberta (HQCA) Year-End Report
- Public Interest Disclosure (Whistleblower Protection) Act
- Surgical Contracts
- List of AHS Funded Facilities
- Bed Numbers – by Zone

PARTNER FOUNDATIONS & HEALTH TRUSTS

Foundations & Health Trusts, AHS, and donors across the province, share a commitment to local health care that has tremendous impact on patient experiences and care. Foundations and trusts are important partners with AHS, and we are grateful for their dedication and support. Our foundations raised approximately $198 million yearly.

Alberta Cancer Foundation: raised $35.2 million in 2014

The Alberta Cancer Foundation invests in clinical cancer trials on an ongoing basis and committed another $3.6 million through to 2014. As well, the foundation has invested more than $100 million in cancer research over the past five years, and that's great news for Sandra Montoya-Logan, cancer free for four years now.

Photo: Sandra Montoya-Logan and Kelly Millham conquered 202 stairs at the end of their walk, and raised a cheer for conquering cancer.

South Zone: 12 foundations raised $5.5 million in 2014

The Cardston & District Health Foundation purchased the Stryker Cross-Pin System for the Cardston Health Centre, which assists surgeons in knee surgeries. At a cost of $27,000, the system helps surgeons reconstruct the ACL (anterior cruciate ligament) by taking a graft from the patient's hamstring tendon and using it to replace the ligament in the front of the knee. A titanium cross-pin is implanted in the knee to keep the grafted ligament in place.

Bassano & District Health Foundation, Bow Island & District Health Foundation, Brooks & District Health Foundation, Cardston & District Health Foundation, Chinook Regional Hospital Foundation, Crowsnest Pass Health Foundation, Fort Macleod & District Health Foundation, Medicine Hat & District Health Foundation, North County Health Foundation, Oyen & District Health Care Foundation, Taber and District Health Foundation, Windy Slopes Health Foundation

Photo: RNs Jenna Heggie and Brent Stock display the Stryker Cross-Pin System, used to repair the damaged anterior cruciate ligament in the knee, at the Cardston Health Centre.

Calgary Zone: 11 foundations raised $71.8 million in 2014

The Claresholm & District Health Foundation helped the Claresholm General Hospital purchase an adult training mannequin for $6,507 and a pediatric training mannequin for $4,478. The mannequins present like real patients complete with all the vital signs like blood pressure and heart rate. Training simulations are critical for staff to keep their skills current with new knowledge and technology, while holding real time simulated hands-on emergencies.

Airdrie Health Foundation, Alberta Children's Hospital Foundation, Calgary Health Trust, Canmore & Area Health Care Foundation, Claresholm & District Health Foundation, EMS Foundation, High River District Health Care Foundation, Rosebud Health Foundation, Sheep River Health Trust, Strathmore District Health Foundation, Vulcan County Health & Wellness Foundation

Photo: Clinical educator Barry Arnestad left, student nurse Kelsey Dunlop, Dr. Jeff Jones, and registered nurse Darlene Jensen-Slot, take part in a training scenario on an adult mannequin at Claresholm General Hospital.

Central Zone: 15 foundations raised $9.5 million in 2014

The Lacombe Health Trust helped purchase three new bath lifts for the Lacombe Hospital and Care Centre continuing care residents at a cost of $35,000. The high quality lifts are compact, include a built-in scale and transport residents from bed to bath, greatly lessening the physical strain on staff.

Consort Hospital Foundation, Coronation Health Centre Foundation, David Thompson Health Trust, Daysland Hospital Foundation, Drayton Valley Health Services Foundation, Drumheller Area Health Foundation, Lacombe Health Trust, Ponoka and District Health Foundation, Provost & District Health Services Foundation, Red Deer Regional Foundation, Stettler Health Services Foundation, Tofield and Area Health Services Foundation, Viking Health Foundation, Wainwright and District Community Foundation, Wetaskiwin Health Foundation

Photo: Laura Robitaille, former Continuing Care Manager at Lacombe Hospital and Care Centre, left and resident Geraldine Gordon display one of the new bath lifts.

Edmonton Zone: 12 foundations raised $58.8 million in 2014

The Royal Alexandra Hospital Foundation raised $3.3M to help the Lois Hole Hospital for Women at the Royal Alexandra Hospital purchase the da Vinci Robotic Surgical System. The robotic device is minimally invasive and requires a few small incisions to operate on uterine and cervical cancers. The system allows for enhanced vision, precision, dexterity and control during complex procedures, and creates real-time views of crisp, sharp images displayed on a magnified 3D high-definition monitor.

Black Gold Health Foundation, Capital Care Foundation, Devon General Hospital Foundation, Fort Saskatchewan Community Hospital Foundation, Glenrose Rehabilitation Hospital Foundation, Mental Health Foundation, Royal Alexandra Hospital Foundation, Stollery Children's Hospital Foundation, Strathcona Community Hospital Foundation, Sturgeon Community Hospital Foundation, Tri-Community Health and Wellness Foundation, University Hospital Foundation

Photo: Flanking gynecologic oncologist Dr. Tiffany Wells are fellow surgeons Dr. Valerie Capstick, left, and Dr. Helen Steed with the new da Vinci Robotic Surgical System, used to operate on uterine and cervical cancers, at the Lois Hole Hospital for Women.

North Zone: 16 foundations raised $4.4 million in 2014

The Grimshaw/Berwyn and District Hospital Foundation put a spotlight on eye injuries by helping the Grimshaw/ Berwyn and District Community Health Centre purchase a slit lamp for the emergency department. Costing $17,000, and used in both emergency and non-emergency situations, the specialized diagnostic tool combines a microscope with a concentrated beam of light to examine parts of the eye.

Beaverlodge Hospital Foundation, Fairview Health Complex Foundation, Grande Cache Hospital Foundation, Grimshaw/ Berwyn Hospital Foundation, Hinton Health Care Foundation, Hythe Nursing Home Foundation, Jasper Healthcare Foundation, Northern Lights Health Foundation, Northwest Health Foundation, Peace River & District Health Foundation, Queen Elizabeth II Hospital Foundation, Regional EMS Foundation, St. Paul and District Hospital Foundation, Swan Hills Hospital Foundation, Two Hills Health Centre Foundation, Valleyview Health Centre Foundation

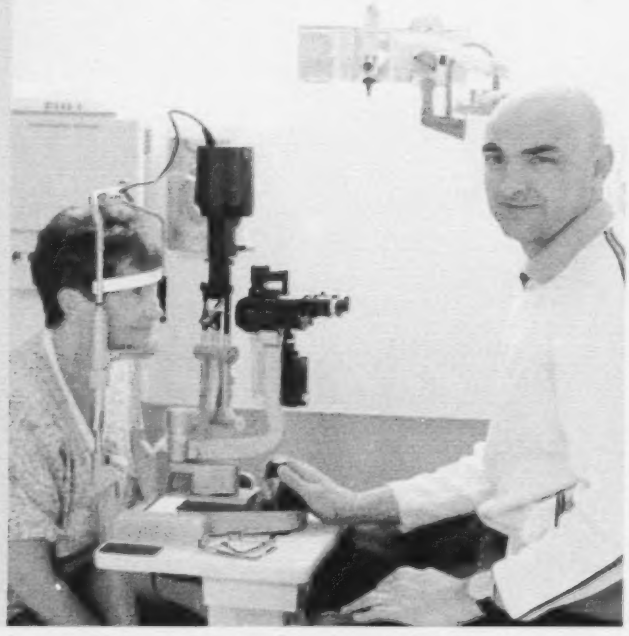


Photo: Dr. Hansie De Kock demonstrates the slit lamp on Jean Connolley, a unit clerk at the Grimshaw/Berwyn and District Community Health Centre.

HEALTH QUALITY COUNCIL OF ALBERTA

AHS continues to partner with the Health Quality Council of Alberta (HQCA) to promote and improve patient safety and health service quality on a provincewide basis. This plays an important part in AHS working towards achieving its mission to provide a patient-focused, quality health system that is accessible and sustainable for all Albertans.

The reviews conducted by the Health Quality Council of Alberta on AHS' programs and services have been integral towards achieving our goal of a high quality health system. The Health Quality Council of Alberta has provided recommendations as part of the following reviews completed in 2014-15:

- Total Parenteral Nutrition Review - June 2014.
- Review of Quality Assurance in Continuing Care Health Services in Alberta - April 2014.
- Chart Review of Fixed-Wing Medevac Patients who Landed at the Edmonton International Airport - January 2015.

AHS continues to implement the recommendations provided by Health Quality Council of Alberta reviews completed prior to 2014-15:

- Review of Alberta Health Services' Continuing Care Wait List: First Available Appropriate Living Option Policy - March 2014.
- Continuity of Patient Care Study - December 2013.
- Review of Operations of Ground Emergency Medical Services in Alberta - January 2013.
- Quality of Anatomical Pathology Specimen Preparation and Interpretation 2010-11 - October 2012.
- Quality Assurance Review of the Three Medication and One Expressed Breast Milk Incidents at the Alberta Children's Hospital, Calgary, Alberta - March 2010.
- Review of Infection Prevention and Control in the High Prairie Health Complex (focusing on the re-use of the single-use syringes) - July 2009.
- Review of Topotecan/Raltitrexed Medication Incident at the Cross Cancer Institute - January 2009.

AHS implemented all recommendations provided by the Health Quality Council of Alberta and a full review was closed during the 2014-15 year:

- Review of the Quality of Care and Safety of Patients Requiring Access to Emergency Department Care and Cancer Surgery and the Role and Process of Physician Advocacy - February 2012.
- Review of Alberta Response to the 2009 H1N1 Influenza Pandemic - December 2010.

PUBLIC INTEREST DISCLOSURE (WHISTLEBLOWER PROTECTION) ACT (PIDA)

On June 1, 2013, the provincial government enacted new legislation surrounding the *Public Interest Disclosure (Whistleblower Protection) Act (PIDA)* and Regulations. The new legislation protects employees when making disclosures of certain kinds of wrongdoing they observe in the work place.

The purpose of the Act includes:

- facilitating the disclosure of wrongdoing
- protecting those who make a disclosure from reprisal
- resolving recommendations arising from investigations
- promoting confidence in the public sector

In 2009, AHS established a solid foundation for leading this work across the organization by approving the AHS Safe Disclosure/Whistleblower Policy and appointing a Chief Ethics & Compliance Officer, who, under the Act, is also the AHS Designated Officer for PIDA.

Over the past six years, AHS has:

- Developed an internal process and procedures to manage reports of wrongdoing (detailed in the Safe Disclosure/ Whistleblower Policy Frequently Asked Questions).
- Provided resources and ongoing training to managers and staff about PIDA and the internal disclosure process.

In compliance with legislated reporting requirements, from April 1, 2014 to March 31, 2015, there have been no disclosures under PIDA to the AHS Designated Officer; as such, no AHS investigations are underway and no actions have been taken.

Of note: the AHS Designated Officer coordinates all PIDA disclosures pertaining to AHS, including those that may originate externally via the provincial PIDA Commissioner/Office of the Ombudsman.

SURGICAL CONTRACTS

AHS contracts services with multiple Non-Hospital Surgical Facilities (NHSF) to provide insured surgical services for dermatology, ophthalmology, oral maxillofacial, otolaryngology, plastic surgery and pregnancy terminations. The use of NHSFs enables AHS to obtain quality services to enhance surgical access and alleviate capacity pressures within AHS main operating rooms.

AHS participated in a joint working group with Alberta Health and the College of Physicians and Surgeons of Alberta to coordinate activities addressing quality, safety and compliance with the *Health Care Protection Act* and regulations. The Provincial NHSF Working Group was launched May 2014 which was facilitated and coordinated by AHS' Surgery Strategic Clinical Network. An action plan was completed in September 2014, outlining a response to Office of the Auditor General of Alberta (OAG) and Internal Auditor's NHSF report. A provincial framework for NHSF business was developed including governance, quality measurement, incident reporting, and monitoring.

AHS determines if the contract is appropriate by assessing sustainability of the public system, access to services, patient safety, appropriateness, effectiveness, cost and public benefit. Contracts with NHSFs provide increased choice of service provider for patients and supplement the resources available in hospitals, while providing good value for public dollars.

The following table summarizes the contracts by service area for 2014-2015:

Service Area	Number of Operators	Number of Procedures Performed
Dermatology - Edmonton Zone	1	10
Ophthalmology - Calgary Zone	5	16,550
Ophthalmology - Edmonton Zone	6	4,247
Ophthalmology - North Zone	1	839
Oral and Maxillofacial Surgery - Calgary Zone	10	870
Oral and Maxillofacial Surgery - Edmonton Zone	8	2,342
Otolaryngology (ENT) - Edmonton Zone	2	240
Plastic Surgery - Edmonton Zone	3	292
Pregnancy Termination - Calgary	1	5,142
Pregnancy Termination - Edmonton	1	6,258
There are no surgical contracts with NHSFs in the South and Central Zones that fall under the *Health Care Protection Act* (Alberta).		

LIST OF AHS FUNDED FACILITIES

Facility Type	Description	Explanation
Addiction	Addiction Treatment Beds / Spaces	Facilities with beds and mats for clients with substance use and gambling problems. Includes detoxification, nursing care, assessment, counselling and treatment. Direct services provided by AHS as well as funded and contracted services. Also includes beds for PChAD (Protection of Children Abusing Drugs) program clients and residential beds funded through the Safe Communities Initiative.
Comm. MH	Community Mental Health Beds / Spaces	Mental health support home programs, Canadian Mental Health Association community beds and other mental health community beds/spaces.
Psych	Standalone Psychiatric Facilities	Standalone psychiatric facilities: 1. Alberta Hospital Edmonton (Edmonton) 2. Centennial Centre for Mental Health and Brain Injury (CCMHBI) (Ponoka) 3. Claresholm Centre for Mental Health and Addictions (Claresholm) 4. Southern Alberta Forensic Psychiatric Centre (Calgary) 5. Villa Caritas (Edmonton)
Hospital	Hospital	Acute Care Hospitals where active treatment is provided. • ED reflects facilities with Emergency Departments with lab, diagnostic imaging, out patient and specialty clinics; and no acute care beds or inpatient services. • OP reflects facilities providing ambulatory services including endoscopy and outpatient specialty clinics. • Ca. reflects Cancer Care facilities.
Sub-Acute	Sub-Acute in an Auxiliary Hospital	Sub-acute care provided in Auxiliary Hospital for the purpose of receiving convalescent and/or rehabilitation services, where it is anticipated that they will achieve their functional potential, to enable them to improve their health status and to successfully return to the community.
LTC	Long-Term Care	Long term care is provided in nursing homes and auxiliary hospitals. It is reserved for those with unpredictable and complex health needs, usually multiple chronic and/or unstable medical conditions. Long-term care includes health and personal care services, such as 24-hour nursing care provided by registered nurses or licensed practical nurses.
Palliative	Palliative	Facilities where a designated program or bed for the purpose of receiving palliative care services including end of life and symptom alleviation not in an acute care facility. Includes community hospice beds.
SL	Supportive Living	Supportive living includes comprehensive services such as the availability of 24-hour nursing care (levels 3 or 4). Supportive Living 4-Dementia is also available for those individuals living with moderate to severe dementia or cognitive impairment. Albertans accessing supportive living services generally reside in lodges, retirement communities, or supportive living centres.
Cancer	Ca	Cancer Care Services include: Assessments and examinations, supportive care, pain management, prescription of cancer-related medications, education, resource and support counselling and referrals to other cancer centres.
Ambulatory	CACC	A community ambulatory care centre (CACC) is a community-based service delivery site (non-hospital setting) primarily engaged in the provision of ambulatory care diagnostic and treatment services. This includes typically scheduled primary care for clients who do not require hospital outpatient emergency care or inpatient treatment.
	FCC	Family Care Clinic provides primary health care to people and their families in under-serviced areas of Alberta.
	UCC	Urgent Care Centre (UCC) and Advanced Ambulatory Care Centres (AACC) provide assessment, diagnostic and treatment services for unscheduled patients who require immediate medical attention for injuries/illness that require human and technical resources more intensive than what is available in physicians office.
	AACC	

PROVINCIAL OVERVIEW - BEDS AND FACILITIES

PROVINCIAL	Number of Facilities	Beds				
		2010-11	2011-12	2012-13	2013-14	2014-15
Community Ambulatory Care						
Urgent Care Centres	7	Not Applicable				
Ambulatory Care Centres	7					
Family Care Clinics	3					
Public Health Centres	132					
Addiction and Mental Health						
Addiction	38	n/a	802	810	855	883
Community Mental Health	24	378	522	539	579	601
Standalone Psychiatric	5	884	918	978	967	955
Acute Care						
Urban	10	8,009	8,114	8,226	8,311	8,471
Community	88					
Regional	5					
Standalone Emergency Departments	2	Not Applicable				
Ambulatory Surgical Centre Hospital	1					
Cancer Care						
Cancer Centres	13	Not Applicable				
Cancer Clinics	4					
Continuing Care (long-term care, supportive living & palliative)						
Long-Term Care	320 (111 Contracted Care)	14,569	14,734	14,553	14,370	14,523
Supportive Living		6,104	6,941	7,979	8,497	9,219
Community Hospice, Palliative & End of Life Care	7	181	182	202	202	208
Total Continuing Care		**20,854**	**21,857**	**22,734**	**23,069**	**23,950**

Over the last five years, AHS has increased addiction capacity by 9 per cent, community mental health by 59 per cent, acute care capacity by approximately 6 per cent and continuing care by 15 per cent, with over 51 per cent increase in supportive living capacity.

ZONE OVERVIEW - BEDS AND FACILITIES

This section contains an overview of the facilities that support health care throughout the province and the beds or spaces within them, broken down provincially or by zone.

SOUTH ZONE	Number of Facilities	Beds				
		2010-11	2011-12	2012-13	2013-14	2014-15
Community Ambulatory Care						
Ambulatory Care Centres	2	Not Applicable				
Public Health Centres	17					
Addiction and Mental Health						
Addiction	5	n/a	53	53	64	64
Community Mental Health	3	n/a	n/a	n/a	37	37
Acute Care						
Regional	2	654	654	654	644	680
Community	12					
Cancer Care						
Cancer Centres	2	Not Applicable				
Continuing Care (long-term care, supportive living & palliative)						
Long-Term Care	47	945	885	885	849	849
Supportive Living		1,349	1,565	1,650	1,684	1,720
Community Palliative & End of Life Care		10	10	20	20	20
Total Continuing Care		**2,304**	**2,460**	**2,555**	**2,553**	**2,589**

Over the last five years, South Zone has increased addiction capacity by 6 per cent, acute care capacity by 4 per cent and continuing care by 12 per cent with over 28 per cent increase in supportive living capacity.

SOUTH ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Sub-acute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Bassano Health Centre	X	Bassano				4			8		**12**		
Crowsnest Pass Health Centre	X	Blairmore				16			58		**74**		
York Creek Lodge		Blairmore								20	**20**		
Bow Island Health Centre	X	Bow Island				10			20		**30**		
Pleasant View Lodge		Bow Island								20	**20**		
Brooks Health Centre	X	Brooks				37			15		**52**		
Orchard Manor		Brooks								25	**25**		
Sunrise Gardens		Brooks								84	**84**		
Cardston Health Centre	X	Cardston				19			12		**31**		
Chinook Lodge		Cardston								20	**20**		
Good Samaritan Lee Crest		Cardston								95	**95**		
Coaldale Health Centre	X	Coaldale				OP			44		**44**		
Sunny South Lodge		Coaldale								45	**45**		
Extendicare Fort MacLeod		Fort MacLeod							50		**50**		
Foothills Detox Centre		Fort MacLeod	14								**14**		
Fort MacLeod Health Centre	X	Fort MacLeod				4					**4**		
MacLeod Pioneer Lodge		Fort MacLeod								10	**10**		
Chinook Regional Hospital	X	Lethbridge				287					**287**		
Jack Ady Cancer Centre	X	Lethbridge	Co-located same campus as Chinook Regional Hospital									Ca	
Canadian Mental Health Association Crisis Beds		Lethbridge		5							**5**		
Canadian Mental Health Association Laura House		Lethbridge		7							**7**		
Columbia Assisted Living		Lethbridge								50	**50**		
Edith Cavell Care Centre		Lethbridge							120		**120**		
Extendicare Fairmont Park		Lethbridge								140	**140**		
Golden Acres Lodge		Lethbridge								45	**45**		
Good Samaritan Park Meadows Village		Lethbridge								121	**121**		
Good Samaritan West Highlands		Lethbridge								100	**100**		
Legacy Lodge		Lethbridge								104	**104**		
SASHA Group Home		Lethbridge		25							**25**		
South Country Treatment Centre		Lethbridge	21								**21**		
Southern Alcare Manor		Lethbridge	13								**13**		
St. Michael's Health Centre		Lethbridge					24	10	72	48	**154**		

SOUTH ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Sub-acute	Palliative	LTC	SL	Total	Cancer	Ambulatory
St. Therese Villa		Lethbridge								200	**200**		
Youth Residential Services	X	Lethbridge	8								**8**		
Good Samaritan Garden Vista		Magrath								35	**35**		
Magrath Health Centre	X	Magrath											CACC
Club Sierra		Medicine Hat							50	31	**81**		
Cypress View		Medicine Hat								41	**41**		
Good Samaritan South Ridge Village		Medicine Hat							80	40	**120**		
Leisure Way		Medicine Hat								17	**17**		
Meadow Lands		Medicine Hat								10	**10**		
Medicine Hat Recovery Centre	X	Medicine Hat	8								**8**		
Medicine Hat Regional Hospital	X	Medicine Hat				246					**246**		
Margery E. Yuill Cancer Centre	X	Medicine Hat	Co-located same campus as Medicine Hat Regional Hospital									Ca	
Riverview Care Centre		Medicine Hat							118		**118**		
St. Joseph's Home - Carmel Hospice		Medicine Hat						10		10	**20**		
Sunnyside Care Centre		Medicine Hat							100	24	**124**		
The Wellington Retirement Residence		Medicine Hat								50	**50**		
Valleyview		Medicine Hat							30	5	**35**		
Milk River Health Centre	X	Milk River				ED			24		**24**		
Prairie Rose Lodge		Milk River								10	**10**		
Big Country Hospital	X	Oyen				10			30		**40**		
Piyami Health Centre	X	Picture Butte											CACC
Piyami Lodge		Picture Butte								20	**20**		
Piyami Place		Picture Butte								15	**15**		
Good Samaritan Vista Village		Pincher Creek								75	**75**		
Pincher Creek Health Centre	X	Pincher Creek				16			3		**19**		
Good Samaritan Prairie Ridge		Raymond								85	**85**		
Raymond Health Centre	X	Raymond				12			5		**17**		
Clearview Lodge		Taber								20	**20**		
Good Samaritan Linden View		Taber								105	**105**		
Taber Health Centre	X	Taber				19			10		**29**		
Total South Zone			**64**	**37**	**0**	**680**	**24**	**20**	**849**	**1,720**	**3,394**		

This section contains an overview of the facilities that support health care throughout the province and the beds or spaces within them, broken down provincially or by zone.

CALGARY ZONE	Number of Facilities	Beds				
		2010-11	2011-12	2012-13	2013-14	2014-15
Community Ambulatory Care						
Urgent Care Centres	6	Not Applicable				
Ambulatory Care Centres	1					
Family Care Clinic	1					
Public Health Centres	22					
Addiction and Mental Health						
Urban	13	n/a	273	274	296	296
Community	9	347	332	336	342	336
Standalone Psychiatric	2	129	133	153	153	141
Acute Care						
Urban	5	2,544	2,588	2,691	2,784	2,832
Community	8					
Ambulatory Surgical Centre Hospital	1	Not Applicable				
Cancer Care						
Cancer Centres	3	Not Applicable				
Continuing Care (long-term care, supportive living & palliative)						
Long-Term Care	62 (53 Contracted Care)	4,968	5,083	5,082	5,003	5,151
Supportive Living		794	934	1,270	1,431	1,912
Community Hospice, Palliative & End of Life Care	7	99	95	95	95	95
Total Continuing Care		**5,861**	**6,112**	**6,447**	**6,529**	**7,158**

Over the last five years, Calgary Zone has increased addiction capacity by 8 per cent; standalone psychiatric by 9 per cent, acute care capacity by 11 per cent and continuing care by 22 per cent with over 141 per cent increase in supportive living capacity.

CALGARY ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Sub-acute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Airdrie Regional Health Centre	X	Airdrie											UCC
Bethany Airdrie		Airdrie							74		**74**		
Mineral Springs Hospital		Banff				22			25		**47**		
Oilfields General Hospital	X	Black Diamond				15			30		**45**		
Agape Hospice		Calgary						20			**20**		
Alberta Children's Hospital	X	Calgary				141					**141**		
Alpha House		Calgary	40								**40**		
Approved Homes - Mental Health		Calgary		117							**117**		
Aspen Family and Community Network		Calgary	6	3							**9**		
Aventa Addiction Treatment for Women		Calgary	48								**48**		
Bethany Calgary		Calgary							446		**446**		
Bethany Harvest Hills		Calgary							60		**60**		
Beverly Centre Glenmore		Calgary							208		**208**		
Beverly Centre Lake Midnapore		Calgary							270		**270**		
Bow Crest Care Centre		Calgary							150		**150**		
Bow View Manor		Calgary							169		**169**		
Calgary Community Rehab Program		Calgary		6							**6**		
Canadian Mental Health Association		Calgary		123							**123**		
Canadian Mental Health Association (Hamilton House)		Calgary		8							**8**		
Canadian Mental Health Association (Robert's House)		Calgary		9							**9**		
Carewest Colonel Belcher	X	Calgary							175	30	**205**		
Carewest Dr. Vernon Fanning Centre	X	Calgary					98		191		**289**		
Carewest Garrison Green	X	Calgary							200		**200**		
Carewest George Boyack	X	Calgary							221		**221**		
Carewest Glenmore Park	X	Calgary					147				**147**		
Carewest Nickle House	X	Calgary								10	**10**		
Carewest Rouleau Manor	X	Calgary							77		**77**		
Carewest Royal Park	X	Calgary							50		**50**		
Carewest Sarcee	X	Calgary					35	15	85		**135**		

CALGARY ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Sub-acute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Carewest Signal Pointe	X	Calgary							54		**54**		
Centre of Hope - Salvation Army		Calgary	30								**30**		
Clifton Manor		Calgary							258		**258**		
Community Living Alternatives for the Mentally Disabled Association (Community LAMDA)		Calgary		62							**62**		
East Calgary Health Centre	X	Calgary											FCC
Eau Claire Retirement Residence		Calgary								73	**73**		
Edgemont Retirement Residence		Calgary								31	**31**		
Enviros Wilderness School Association		Calgary	10								**10**		
Evanston Grand Village		Calgary								102	**102**		
Extendicare Cedars Villa		Calgary							248		**248**		
Extendicare Hillcrest		Calgary							112		**112**		
Father Lacombe Care Centre		Calgary							114		**114**		
Foothills Medical Centre	X	Calgary				1,095					**1,095**		
Fresh Start Recovery Centre		Calgary	1								**1**		
Glamorgan Care Centre		Calgary							52		**52**		
Holy Cross Manor		Calgary								100	**100**		
Hull Homes Detox/PChaD		Calgary	12								**12**		
Intercare at Millrise		Calgary							51		**51**		
Intercare Brentwood Care Centre		Calgary							257		**257**		
Intercare Chinook Care Centre		Calgary						14	203		**217**		
Intercare Southwood Care Centre		Calgary						24	215		**239**		
Mayfair Care Centre		Calgary							142		**142**		
McKenzie Towne Continuing Care Centre		Calgary							150		**150**		
McKenzie Towne Retirement Residence		Calgary								42	**42**		
Millrise Place		Calgary								40	**40**		
Monterey Place		Calgary								107	**107**		
Mount Royal Care Centre		Calgary							93		**93**		
Newport Harbour Care Centre		Calgary							127		**127**		
Oxford House		Calgary	23								**23**		
Personal Care Homes - Continuing Care		Calgary								223	**223**		

CALGARY ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Sub-acute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Peter Lougheed Centre	X	Calgary				562					**562**		
Prince of Peace Harbour		Calgary								32	**32**		
Prince of Peace Manor		Calgary								30	**30**		
Recovery Acres		Calgary	13								**13**		
Renfrew Recovery Centre	X	Calgary	40								**40**		
Richmond Road Diagnostic & Treatment Centre	X	Calgary				OP							
Rocky Ridge Retirement Community		Calgary								29	**29**		
Rockyview General Hospital	X	Calgary				617					**617**		
Rosedale Hospice		Calgary						7			**7**		
Rotary Flames House	X	Calgary						7			**7**		
Scenic Acres Retirement Residence		Calgary								26	**26**		
SCOPE Hunterview House		Calgary		1							**1**		
Sheldon M. Chumir Health Centre	X	Calgary											UCC
South Calgary Health Centre	X	Calgary											UCC
South Health Campus	X	Calgary				269					**269**		
Southern Alberta Foresenic Psychiatric Centre	X	Calgary			33						**33**		
Sunridge Medical Gallery	X	Calgary											CACC
Sunrise Native Addiction Services Society		Calgary	24								**24**		
Tom Baker Cancer Centre	X	Calgary										Ca	
Walden Heights Seniors Community		Calgary							58	234	**292**		
Wentworth Manor/The Residence and The Court		Calgary							83	57	**140**		
Whitehorn Village		Calgary								53	**53**		
Wing Kei Care Centre		Calgary							135		**135**		
Wing Kei Greenview		Calgary								95	**95**		
Woods Homes ENP (Exceptional Needs Program)		Calgary		7							**7**		
Youville Women's Residence		Calgary	1								**1**		
Canmore General Hospital	X	Canmore				21			23		**44**		
Bow Valley Community Cancer Centre	X	Canmore	Co-located same campus as Canmore General Hospital									Ca	

CALGARY ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Sub-acute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Claresholm Centre for Mental Health and Addictions	X	Claresholm			108						**108**		
Claresholm General Hospital	X	Claresholm				16					**16**		
Lander Treatment Centre	X	Claresholm	48								**48**		
Willow Creek Continuing Care Centre	X	Claresholm							100		**100**		
Bethany Cochrane		Cochrane							78		**78**		
Cochrane Community Health Centre	X	Cochrane											UCC
Aspen Ridge Lodge		Didsbury								30	**30**		
Bethany Didsbury		Didsbury								100	**100**		
Didsbury District Health Services	X	Didsbury				16			21		**37**		
High River General Hospital	X	High River				27			50		**77**		
High River Community Cancer Centre	X	High River	Co-located same campus as High River General Hospital									Ca	
Sunrise Village High River		High River								108	**108**		
Silver Willow Lodge		Nanton								38	**38**		
Foothills Country Hospice		Okotoks						8			**8**		
Okotoks Health and Wellness Centre	X	Okotoks											UCC
Revera Heartland		Okotoks								40	**40**		
Strafford Foundation Tudor Manor		Okotoks								152	**152**		
Agecare Sagewood Seniors Community		Strathmore							35	30	**165**		
Strathmore District Health Services	X	Strathmore				23					**23**		
Extendicare Vulcan		Vulcan							46		**46**		
Vulcan Community Health Centre	X	Vulcan				8			15		**23**		
Total Calgary Zone			**296**	**336**	**141**	**2,832**	**280**	**95**	**5,151**	**1,912**	**11,043**		

This section contains an overview of the facilities that support health care throughout the province and the beds or spaces within them, broken down provincially or by zone.

CENTRAL ZONE	Number of Facilities	Beds				
		2010-11	2011-12	2012-13	2013-14	2014-15
Community Ambulatory Care						
Ambulatory Care Centres	2	Not Applicable				
Public Health Centres	34					
Addiction and Mental Health						
Addiction	5	n/a	63	67	67	67
Community Mental Health	2	25	31	31	31	31
Standalone Psychiatric	1	330	330	330	330	330
Acute Care						
Regional	1	1,087	1,086	1,096	1,091	1,095
Community	29					
Cancer Care						
Cancer Centres	1	Not Applicable				
Cancer Clinics	4					
Continuing Care (long-term care, supportive living & palliative)						
Long-Term Care	72	2,352	2,351	2,351	2,287	2,297
Supportive Living		948	1,015	1,149	1,350	1,407
Community Palliative & End of Life Care		10	10	10	10	10
Total Continuing Care		**3,310**	**3,376**	**3,510**	**3,647**	**3,714**

Over the last five years, Central Zone has increased addiction capacity by 6 per cent, community mental health by 24 per cent, acute care capacity by 1 per cent, and continuing care by 12 per cent with over 48 per cent increase in supportive living capacity.

CENTRAL ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Sub-acute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Bashaw Care Centre	X	Bashaw											CACC
Bashaw Meadows		Bashaw								30	**30**		
Bentley Care Centre	X	Bentley							16		**16**		
Slim Thorpe Recovery Centre		Blackfoot	7								**7**		
Breton Health Centre	X	Breton							23		**23**		
Bethany Meadows		Camrose							65	30	**95**		
Faith House		Camrose								20	**20**		
Louise Jensen Care Centre		Camrose							65		**65**		
Memory Lane		Camrose								25	**25**		
Rosehaven Care Centre		Camrose							75		**75**		
St. Mary's Hospital		Camrose				76					**76**		
Camrose Community Cancer Centre		Camrose	Co-located same campus as St. Mary's Hospital									Ca	
Sunrise Village Camrose		Camrose								82	**82**		
Viewpoint		Camrose								20	**20**		
Our Lady of the Rosary Hospital		Castor				5			22		**27**		
Consort Hospital and Care Centre	X	Consort				5			15		**20**		
Coronation Hospital and Care Centre	X	Coronation				10			23	19	**52**		
Daysland Health Centre	X	Daysland				26					**26**		
Providence Place		Daysland								16	**16**		
Drayton Valley Hospital and Care Centre	X	Drayton Valley				32			50		**82**		
Drayton Valley Community Cancer Centre	X	Drayton Valley	Co-located same campus as Drayton Valley Hospital and Care Centre									Ca	
Serenity House	X	Drayton Valley								12	**12**		
Sunrise Village Drayton Valley		Drayton Valley								16	**16**		
Drumheller Health Centre	X	Drumheller				33			88		**121**		
Drumheller Community Cancer Centre	X	Drumheller	Co-located same campus as Drumheller Health Centre									Ca	
Grace House		Drumheller	5								**5**		
Hillview Lodge		Drumheller								36	**36**		
Eckville Manor House		Eckville								15	**15**		
Galahad Care Centre	X	Galahad							20		**20**		
Hanna Health Centre	X	Hanna				17			61		**78**		
Hardisty Health Centre	X	Hardisty				5			15		**20**		

CENTRAL ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Sub-acute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Innisfail Health Centre	X	Innisfail				28			78		**106**		
Sunset Manor		Innisfail								96	**96**		
Islay Assisted Living	X	Islay								20	**20**		
Killam Health Care Centre		Killam				5			45		**50**		
Royal Oak Manor		Lacombe								111	**111**		
Lacombe Hospital and Care Centre	X	Lacombe				35			75		**110**		
Lamont Health Care Centre		Lamont				15			105		**120**		
Westview Care Community		Linden							37		**37**		
Points West Living Lloydminster		Lloydminister								60	**60**		
Dr. Cooke Extended Care Centre		Lloydminster							105		**105**		
Lloydminster Hospital		Lloydminster (Sask)				39					**39**		
Lloydminster Community Cancer Centre		Lloydminster (Sask)	Co-located same campus as Lloydminster Hospital									Ca	
Mannville Care Centre	X	Mannville							23	-	**23**		
Mary Immaculate Hospital		Mundare							30	-	**30**		
Eagle View Lodge		Myrnam								9	**9**		
Enviros Wilderness School (Shunda Creek)		Nordegg	10								**10**		
Olds Hospital and Care Centre	X	Olds				33			50		**83**		
Sunrise Encore Olds		Olds								60	**60**		
Sunrise Village Olds		Olds								20	**20**		
Centennial Centre for Mental Health & Brain Injury	X	Ponoka			330						**330**		
Northcott Care Centre (Ponoka)		Ponoka							73		**73**		
Ponoka Hospital and Care Centre	X	Ponoka				29			28		**57**		
Sunrise Village Ponoka		Ponoka								20	**20**		
Provost Health Centre	X	Provost				17			47		**64**		
Addiction Counselling & Prevention Services	X	Red Deer	5								**5**		
Bethany CollegeSide (Red Deer)		Red Deer							112		**112**		
Extendicare Michener Hill		Red Deer							220	60	**280**		
Kentwood Place	X	Red Deer		25							**25**		
Pines Lodge		Red Deer								20	**20**		

CENTRAL ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Sub-acute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Red Deer Hospice		Red Deer						10			**10**		
Red Deer Regional Hospital Centre	X	Red Deer				370					**370**		
Central Alberta Cancer Centre	X	Red Deer	Co-located same campus as Red Deer Regional Hospital Centre									Ca	
Safe Harbour Society		Red Deer	40								**40**		
Villa Marie		Red Deer								100	**100**		
West Park Lodge		Red Deer								36	**36**		
Rimbey Hospital and Care Centre	X	Rimbey				23			84		**107**		
Clearwater Centre		Rocky Mountain House							40	39	**79**		
Rocky Mountain House Health Centre	X	Rocky Mountain House				31					**31**		
Stettler Hospital and Care Centre	X	Stettler				26			50		**76**		
Points West Living Stettler		Stettler								88	**88**		
Sundre Hospital and Care Centre	X	Sundre				14			15		**29**		
Bethany Sylvan Lake		Sylvan Lake							40	21	**61**		
Sylvan Lake Community Health Centre	X	Sylvan Lake											CACC
Chateau Three Hills		Three Hills								15	**15**		
Three Hills Health Centre	X	Three Hills				21			24		**45**		
Tofield Health Centre	X	Tofield				16			50		**66**		
St. Mary's Health Care Centre		Trochu							28		**28**		
Two Hills Health Centre	X	Two Hills				27			56		**83**		
Heritage House		Vegreville								42	**42**		
Points West Living Century Park		Vegreville								40	**40**		
St. Joseph's General Hospital		Vegreville				25					**25**		
Vegreville Care Centre	X	Vegreville							60		**60**		
Vegreville Manor		Vegreville								15	**15**		
Vermilion Health Centre	X	Vermilion				26			48		**74**		
Vermilion Valley Lodge		Vermilion								40	**40**		
Extendicare Viking		Viking							60		**60**		
Viking Health Centre	X	Viking				16					**16**		
Points West Living Wainwright		Wainwright								59	**59**		

CENTRAL ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Sub-acute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Wainwright Health Centre	X	Wainwright				25			69		**94**		
Good Samaritan Good Shepherd Lutheran Home		Wetaskiwin								69	**69**		
Sunrise Village Wetaskiwin		Wetaskiwin								20	**20**		
Wetaskiwin Hospital and Care Centre	X	Wetaskiwin				65			107		**172**		
Wetaskiwin Meadows		Wetaskiwin								26	**26**		
Wetaskiwin Serenity House (Bosco)		Wetaskiwin		6							**6**		
Total Central Zone			**67**	**31**	**330**	**1,095**	**0**	**10**	**2,297**	**1,407**	**5,237**		

This section contains an overview of the facilities that support health care throughout the province and the beds or spaces within them, broken down provincially or by zone.

EDMONTON ZONE	Number of Facilities	Beds				
		2010-11	2011-12	2012-13	2013-14	2014-15
Community Ambulatory Care						
Urgent Care Centres	1	Not Applicable				
Family Care Clinic	1					
Public Health Centres	20					
Addiction and Mental Health						
Addiction	9	n/a	287	290	312	329
Community Mental Health	9	n/a	153	166	164	192
Standalone Psychiatric	2	425	455	495	484	484
Acute Care						
Urban	5	2,823	2,885	2,885	2,893	2,947
Community	7					
Standalone Emergency Departments	2	Not Applicable				
Cancer Care						
Cancer Centre	1	Not Applicable				
Continuing Care (long-term care, supportive living & palliative)						
Long-Term Care	85 (58 Contracted Care)	4,978	5,085	4,963	4,963	4,961
Supportive Living		2,724	3,011	3,354	3,363	3,477
Community Palliative & End of Life Care		63	64	64	64	70
Total Continuing Care		**7,765**	**8,160**	**8,381**	**8,390**	**8,508**

Over the last five years, Edmonton Zone has increased addiction capacity by 15 per cent, community mental health by 25 per cent, standalone psychiatric by 14 per cent, acute care capacity by 4 per cent, continuing care by 10 per cent with over 28 per cent increase in supportive living capacity and palliative capacity by 11 per cent.

EDMONTON ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Sub-acute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Kipohtakawmik Elders Lodge		Alexander Reserve								13	**13**		
Place Beausejour		Beaumont								46	**46**		
Devon General Hospital	X	Devon				13			11		**24**		
Addiction Recovery Centre	X	Edmonton	42								**42**		
Alberta Hospital Edmonton	X	Edmonton			334						**334**		
Allen Gray Continuing Care Centre		Edmonton							156		**156**		
Allendale House		Edmonton		10							**10**		
Ambrose Place		Edmonton		28							**28**		
Anderson Hall	X	Edmonton		14							**14**		
Balwin Villa (Excel Society)		Edmonton								104	**104**		
CapitalCare Dickinsfield	X	Edmonton							275		**275**		
CapitalCare Dickinsfield Duplexes	X	Edmonton								14	**14**		
CapitalCare Grandview	X	Edmonton					34		147		**181**		
CapitalCare Laurier House Lynnwood	X	Edmonton								80	**80**		
CapitalCare Lynnwood	X	Edmonton							284		**284**		
CapitalCare McConnell Place North	X	Edmonton								36	**36**		
CapitalCare McConnell Place West	X	Edmonton								36	**36**		
CapitalCare Norwood	X	Edmonton					114	23	68		**205**		
CASA House		Edmonton		20							**20**		
Churchill Retirement Community		Edmonton								35	**35**		
Cross Cancer Institute	X	Edmonton				56					**56**	Ca	
Devonshire Care Centre		Edmonton							132		**132**		
Devonshire Manor		Edmonton								59	**59**		
E4C Meadows Place		Edmonton		16							**16**		
E4C Our Place		Edmonton		10							**10**		
East Edmonton Health Centre	X	Edmonton											FCC
Edmonton Chinatown Care Centre		Edmonton							80	15	**95**		
Edmonton General Continuing Care Centre		Edmonton					20	26	449		**495**		
Edmonton People In Need Batoma House		Edmonton								85	**85**		
Emmanuel Home		Edmonton								15	**15**		
Extendicare Eaux Claires		Edmonton							180		**180**		

EDMONTON ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Sub-acute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Extendicare Holyrood		Edmonton							74		**74**		
Garneau Hall		Edmonton								37	**37**		
George Spady Centre Society		Edmonton	73								**73**		
Glastonbury Village		Edmonton								50	**50**		
Glenrose Rehabilitation Hospital	X	Edmonton				244					**244**		
Good Samaritan Dr. Gerald Zetter Care Centre		Edmonton					10		190		**200**		
Good Samaritan Millwoods Care Centre		Edmonton							60		**60**		
Good Samaritan Southgate Care Centre		Edmonton							226		**226**		
Good Samaritan Wedman House		Edmonton								30	**30**		
Grand Manor		Edmonton								56	**56**		
Grey Nuns Community Hospital		Edmonton				354					**354**		
Hardisty Care Centre		Edmonton							180		**180**		
Henwood Treatment Centre	X	Edmonton	72								**72**		
House Next Door #1, 2, 3		Edmonton		24							**24**		
Innovative Housing - 114 Gravelle		Edmonton								93	**93**		
Innovative Housing - Villa Marguerite		Edmonton								230	**230**		
Jasper Place Continuing Care Centre		Edmonton							100		**100**		
Jellinek House		Edmonton	15								**15**		
Jubilee Lodge Nursing Home		Edmonton							156		**156**		
Laurel Heights		Edmonton								60	**60**		
Lewis Estates Retirement Residence		Edmonton								93	**93**		
Lifestyle Options Riverbend		Edmonton								18	**18**		
Lifestyle Options Terra Losa		Edmonton								77	**77**		
Lifestyle Options Whitemud		Edmonton								77	**77**		
McDougall House		Edmonton	11								**11**		
Miller Crossing Care Centre		Edmonton							155		**155**		
Misericordia Community Hospital		Edmonton				303					**303**		
Northeast Community Health Centre	X	Edmonton				ED							
Ottewell Lodge		Edmonton		38							**38**		
Our House Addiction Recovery Centre		Edmonton	10								**10**		
Recovery Acres Edmonton		Edmonton	34								**34**		

EDMONTON ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Sub-acute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Riverbend Retirement Residence		Edmonton								38	**38**		
Rosedale at Griesbach		Edmonton								165	**165**		
Rosedale Estates		Edmonton								50	**50**		
Royal Alexandra Hospital	X	Edmonton				869					**869**		
Rutherford Heights Retirement Residence		Edmonton								88	**88**		
Saint Thomas Assisted Living Centre		Edmonton								138	**138**		
Salvation Army Grace Manor		Edmonton								83	**83**		
Salvation Army Stepping Stone Supportive Residence		Edmonton								50	**50**		
Shepherd's Care Ashbourne		Edmonton								32	**32**		
Shepherd's Care Greenfield		Edmonton								30	**30**		
Shepherd's Care Kensington		Edmonton							69	87	**156**		
Shepherd's Care Millwoods		Edmonton							147		**147**		
Shepherd's Care Vanguard		Edmonton								97	**97**		
Shepherd's Garden		Edmonton								46	**46**		
South Terrace Continuing Care Centre		Edmonton							114		**114**		
St. Joseph's Auxiliary Hospital		Edmonton						14	188		**202**		
St. Michael's Long Term Care Centre		Edmonton					7		146		**153**		
Stollery Children's Hospital	X	Edmonton				153					**153**		
The Dianne and Irving Kipnes Centre for Veterans	X	Edmonton							120		**120**		
Touchmark at Wedgewood		Edmonton							64		**64**		
Tuoi Hac - Golden Age Manor		Edmonton								91	**91**		
University of Alberta Hospital	X	Edmonton				677					**677**		
Venta Care Centre		Edmonton							148		**148**		
Villa Caritas		Edmonton			150						**150**		
Wild Rose Cottage		Edmonton								27	**27**		
Youth Stabilization & Residential Services	X	Edmonton	21								**21**		
Good Samaritan Society Pembina Village		Evansburg							40		**40**		
Fort Saskatchewan Community Hospital	X	Fort Saskatchewan				36					**36**		
Rivercrest Care Centre		Fort Saskatchewan							85		**85**		

EDMONTON ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Sub-acute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Extendicare Leduc		Leduc							79		**79**		
Leduc Community Hospital	X	Leduc				70					**70**		
Lifestyle Options Leduc		Leduc								74	**74**		
Salem Manor Nursing Home		Leduc							102		**102**		
Aspen House	X	Morinville								74	**74**		
CapitalCare Strathcona	X	Sherwood Park							111		**111**		
CapitalCare Laurier House Strathcona	X	Sherwood Park								42	**42**		
Country Cottage Seniors Residence		Sherwood Park								26	**26**		
Health First Strathcona	X	Sherwood Park	UCC closed May 2014										UCC
Sherwood Care		Sherwood Park							100		**100**		
Strathcona Community Hospital	X	Sherwood Park				ED							
Summerwood Village Retirement Residence		Sherwood Park								80	**80**		
Copper Sky Lodge		Spruce Grove								130	**130**		
Good Samaritan Spruce Grove Centre		Spruce Grove								30	**30**		
Citadel Care Centre		St. Albert							129		**129**		
Citadel Mews West		St. Albert								68	**68**		
Poundmaker's Lodge Treatment Center - Youth Addiction (Safe-Com)		St. Albert	51								**51**		
Rosedale St. Albert		St. Albert								70	**70**		
Sturgeon Community Hospital	X	St. Albert				149					**149**		
Youville Auxiliary Hospital (Grey Nuns) of St. Albert		St. Albert						1	232		**233**		
Good Samaritan George Hennig Place		Stony Plain								30	**30**		
Good Samaritan Stony Plain Care Centre		Stony Plain							126	30	**156**		
WestView Health Centre - Stony Plain	X	Stony Plain				23		6	38		**67**		
Family Care Homes		Various								13	**13**		
Approved Mental Health Care Homes		Various		32							**32**		
Personal Care Homes		Various								241	**241**		
Special Care Homes		Various								156	**156**		
West Country Hearth		Villeneuve								32	**32**		
Total Edmonton Zone			**329**	**192**	**484**	**2,947**	**185**	**70**	**4,961**	**3,477**	**12,645**		

This section contains an overview of the facilities that support health care throughout the province and the beds or spaces within them, broken down provincially or by zone.

NORTH ZONE	Number of Facilities	Beds				
		2010-11	2011-12	2012-13	2013-14	2014-15
Community Ambulatory Care						
Ambulatory Care Centres	2	Not Applicable				
Family Care Clinic	1					
Public Health Centres	38					
Addiction and Mental Health						
Addiction	7	n/a	126	126	127	127
Community Mental Health	1	6	6	6	5	5
Acute Care						
Urban	2	901	901	900	899	917
Community	32					
Cancer Care						
Cancer Centres	6	Not Applicable				
Continuing Care (long-term care, supportive living & palliative)						
Long-Term Care	54	1,326	1,330	1,272	1,268	1,265
Supportive Living		289	416	556	669	703
Community Palliative & End of Life Care		3	3	13	13	13
Total Continuing Care		**1,618**	**1,749**	**1,841**	**1,950**	**1,981**

Over the last five years, North Zone has increased addiction capacity by 1 per cent, acute care capacity by 2 per cent, continuing care by 22 per cent with over 143 per cent increase in supportive living capacity and palliative capacity by 333 per cent.

NORTH ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Sub-acute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Athabasca Healthcare Centre	X	Athabasca				27			23		**50**		
Extendicare Athabasca		Athabasca							50		**50**		
Barrhead Healthcare Centre	X	Barrhead				34					**34**		
Barrhead Community Cancer Centre	X	Barrhead	Co-located same campus as Barrhead Healthcare Centre									Ca	
Dr. W.R. Keir - Barrhead Continuing Care Centre	X	Barrhead							100		**100**		
Shepherd's Care Barrhead		Barrhead								42	**42**		
Beaverlodge Municipal Hospital	X	Beaverlodge				18					**18**		
Bonnyville Healthcare Centre		Bonnyville				33			30		**63**		
Bonnyville Community Cancer Centre		Bonnyville	Co-located same campus as Bonnyville Healthcare Centre									Ca	
Bonnyville Indian Metis Rehab Centre		Bonnyville	20								**20**		
Extendicare Bonnyville		Bonnyville							50		**50**		
Boyle Healthcare Centre	X	Boyle				20					**20**		
Cold Lake Healthcare Centre	X	Cold Lake				24			31		**55**		
Points West Living Cold Lake		Cold Lake								42	**42**		
Ridgevalley Seniors Home		Crooked Creek								15	**15**		
Wabasca/Desmarais Healthcare Centre	X	Desmarais				10					**10**		
Edson Healthcare Centre	X	Edson				22			50		**72**		
Parkland Lodge		Edson								10	**10**		
Elk Point Healthcare Centre	X	Elk Point				12			30		**42**		
Elk Point Heritage Lodge		Elk Point								10	**10**		
Fairview Health Complex	X	Fairview				25		1	66		**92**		
Northern Lights Regional Health Centre	X	Fort McMurray				105			31		**136**		
Fort McMurray Community Cancer Centre	X	Fort McMurray	Co-located same campus as Northern Lights Regional Health Centre									Ca	
Pastew Place Detox Centre		Fort McMurray	11								**11**		
St. Theresa General Hospital	X	Fort Vermilion				26			8		**34**		
Fox Creek Healthcare Centre	X	Fox Creek				4					**4**		
Grande Cache Community Health Complex	X	Grande Cache				12					**12**		
Whispering Pines Seniors Lodge		Grande Cache								15	**15**		
Grande Prairie Care Centre		Grande Prairie							60	60	**120**		
NAC Business & Industry Clinic	X	Grande Prairie	20								**20**		

NORTH ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Sub-acute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Northern Addiction Centre	X	Grande Prairie	43								**43**		
Points West Living Grand Prairie		Grande Prairie						10	50	95	**155**		
Queen Elizabeth II Hospital	X	Grande Prairie				161	10			27	**198**		
Grande Prairie Cancer Centre	X	Grande Prairie	Co-located same campus as QEII Hospital									Ca	
The Gardens at Emerald Park		Grande Prairie								15	**15**		
Youth Detoxification Services	X	Grande Prairie	4								**4**		
Grimshaw/Berwyn and District Community Health Centre	X	Grimshaw				ED		1	19		**20**		
Stone Brook		Grimshaw								56	**56**		
Action North Recovery Centre		High Level	13								**13**		
Northwest Health Centre	X	High Level				21			11		**32**		
High Prairie Health Complex	X	High Prairie				25					**25**		
J.B. Wood Continuing Care Centre	X	High Prairie							37		**37**		
Metis Indian Town Alcohol Association (MITAA Centre)		High Prairie	16								**16**		
Hinton Healthcare Centre	X	Hinton				23					**23**		
Hinton Community Cancer Centre	X	Hinton	Co-located same campus as Bonnyville Healthcare Centre									Ca	
Mountain View Centre		Hinton								52	**52**		
Hythe Continuing Care Centre	X	Hythe							31		**31**		
Jasper Alpine Summit Seniors Lodge		Jasper								16	**16**		
Seton - Jasper Healthcare Centre	X	Jasper				11					**11**		
Heimstaed Lodge		La Crete								54	**54**		
La Crete Continuing Care Centre	X	La Crete						1	22		**23**		
La Crete Health Centre	X	La Crete											AACC
William J. Cadzow - Lac La Biche Healthcare Centre	X	Lac La Biche				23			41		**64**		
Manning Community Health Centre	X	Manning				11			16		**27**		
Extendicare Mayerthorpe		Mayerthorpe							50		**50**		
Mayerthorpe Healthcare Centre	X	Mayerthorpe				25			30		**55**		
Pleasant View Lodge		Mayerthorpe								15	**15**		
Manoir du Lac		McLennan							22	35	**57**		
Sacred Heart Community Health Centre	X	McLennan				20					**20**		
Chateau Lac St. Anne		Onoway								15	**15**		

NORTH ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Sub-acute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Peace River Community Health Centre	X	Peace River				31			40		**71**		
Peace River Community Cancer Centre	X	Peace River	Co-located same campus as Peace River Comm. Health Centre									Ca	
Points West Living Peace River		Peace River								42	**42**		
Radway Continuing Care Centre	X	Radway							30		**30**		
Rainbow Lake Health Centre		Rainbow Lake											
Redwater Health Centre	X	Redwater				14			7		**21**		
Slave Lake Family Care Clinic	X	Slave Lake											FCC
Slave Lake Healthcare Centre	X	Slave Lake				24			20		**44**		
Vanderwell Lodge		Slave Lake								8	**8**		
George McDougall - Smoky Lake Healthcare Centre	X	Smoky Lake				12			23		**35**		
Smoky Lake Continuing Care Centre	X	Smoky Lake							28		**28**		
Central Peace Health Complex	X	Spirit River				12			16		**28**		
Extendicare St. Paul		St. Paul							76		**76**		
St. Therese - St. Paul Healthcare Centre	X	St. Paul				40			30		**70**		
St. Paul Abilities Network		St. Paul		5						6	**11**		
Swan Hills Healthcare Centre	X	Swan Hills				4					**4**		
Valleyview Health Centre	X	Valleyview				20			25		**45**		
Vilna Villa		Vilna								12	**12**		
Smithfield Lodge	X	Westlock								46	**46**		
Westlock Healthcare Centre	X	Westlock				46	8		112		**166**		
Spruce View Lodge		Whitecourt								15	**15**		
Whitecourt Healthcare Centre	X	Whitecourt				22					**22**		
Total North Zone			**127**	**5**	**0**	**917**	**18**	**13**	**1,265**	**703**	**3,048**		

AHS Reported Beds Staffed & In Operation Summary as of March 31, 2015

ZONE	ADDICTION AND MENTAL HEALTH			ACUTE/SUB-ACUTE CARE		CONTINUING CARE - FACILITY LIVING				SUPPORTIVE LIVING (SL)				TOTAL CONTINUING CARE (LTC + SL)	TOTAL CONTINUING CARE INCLUDING PALLIATIVE	TOTAL BEDS
	ADDICTION	COMMUNITY MENTAL HEALTH	PSYCHIATRIC (STANDALONE FACILITY)	ACUTE CARE	SUB-ACUTE (NON-ACUTE CARE FACILITY)	AUXILIARY HOSPITAL	NURSING HOME	LONG-TERM CARE SUBTOTAL (AUXILIARY + NURSING HOME)	COMMUNITY PALLIATIVE & END OF LIFE CARE	SL LEVEL 3	SL LEVEL 4	SL LEVEL 4 DEMENTIA	SUPPORTIVE LIVING SUBTOTAL (SL 3 + SL 4 + SL4D)			
South	64	37	0	680	24	248	601	849	20	305	949	466	1,720	2,569	2,589	3,394
Calgary	296	336	141	2,832	280	1,072	4,079	5,151	95	233	1,180	499	1,912	7,063	7,158	11,043
Central	67	31	330	1,095	0	1,350	947	2,297	10	397	742	268	1,407	3,704	3,714	5,237
Edmonton	329	192	484	2,947	185	2,212	2,749	4,961	70	414	2,116	947	3,477	8,438	8,508	12,645
North	127	5	0	917	18	639	626	1,265	13	195	355	153	703	1,968	1,981	3,048
AHS TOTAL	**883**	**601**	**955**	**8,471**	**507**	**5,521**	**9,002**	**14,523**	**208**	**1,544**	**5,342**	**2,333**	**9,219**	**23,742**	**23,950**	**35,367**

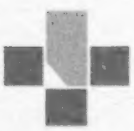
Adjusted From The Annual Report Totals - Reported Beds Staffed & In Operation Summary as of March 31, 2014

ZONE	ADDICTION AND MENTAL HEALTH			ACUTE/SUB-ACUTE CARE		CONTINUING CARE - FACILITY LIVING				SUPPORTIVE LIVING (SL)				TOTAL CONTINUING CARE (LTC + SL)	TOTAL CONTINUING CARE INCLUDING PALLIATIVE	TOTAL BEDS
	ADDICTION	COMMUNITY MENTAL HEALTH	PSYCHIATRIC (STANDALONE FACILITY)	ACUTE CARE	SUB-ACUTE (NON-ACUTE CARE FACILITY)	AUXILIARY HOSPITAL	NURSING HOME	LONG-TERM CARE SUBTOTAL (AUXILIARY + NURSING HOME)	COMMUNITY PALLIATIVE & END OF LIFE CARE	SL LEVEL 3	SL LEVEL 4	SL LEVEL 4 DEMENTIA	SUPPORTIVE LIVING SUBTOTAL (SL 3 + SL 4 + SL4D)			
South	53	37	0	644	24	248	601	849	20	310	933	441	1,684	2,533	2,553	3,311
Calgary	296	342	153	2,784	280	1,112	3,891	5,003	95	229	851	351	1,431	6,434	6,529	10,384
Central	67	31	330	1,091	0	1,340	947	2,287	10	401	701	248	1,350	3,637	3,647	5,166
Edmonton	312	164	484	2,893	185	2,185	2,778	4,963	64	420	2,093	850	3,363	8,326	8,390	12,428
North	127	5	0	899	18	642	626	1,268	13	205	311	153	669	1,937	1,950	2,999
AHS TOTAL	**855**	**579**	**967**	**8,311**	**507**	**5,527**	**8,843**	**14,370**	**202**	**1,565**	**4,889**	**2,043**	**8,497**	**22,867**	**23,069**	**34,288**

Change from March 31, 2014 to March 31, 2015

ZONE	ADDICTION AND MENTAL HEALTH			ACUTE/SUB-ACUTE CARE		CONTINUING CARE - FACILITY LIVING				SUPPORTIVE LIVING (SL)				TOTAL CONTINUING CARE (LTC + SL)	TOTAL CONTINUING CARE INCLUDING PALLIATIVE	TOTAL BEDS
	ADDICTION	COMMUNITY MENTAL HEALTH	PSYCHIATRIC (STANDALONE FACILITY)	ACUTE CARE	SUB-ACUTE (NON-ACUTE CARE FACILITY)	AUXILIARY HOSPITAL	NURSING HOME	LONG-TERM CARE SUBTOTAL (AUXILIARY + NURSING HOME)	COMMUNITY PALLIATIVE & END OF LIFE CARE	SL LEVEL 3	SL LEVEL 4	SL LEVEL 4 DEMENTIA	SUPPORTIVE LIVING SUBTOTAL (SL 3 + SL 4 + SL4D)			
South	11	0	0	36	0	0	0	0	0	-5	16	25	36	36	36	83
Calgary	0	-6	-12	48	0	-40	188	148	0	4	329	148	481	629	629	659
Central	0	0	0	4	0	10	0	10	0	-4	41	20	57	67	67	71
Edmonton	17	28	0	54	0	27	-29	-2	6	-6	23	97	114	112	118	217
North	0	0	0	18	0	-3	0	-3	0	-10	44	0	34	31	31	49
AHS TOTAL	**28**	**22**	**(12)**	**160**	**-**	**(6)**	**159**	**153**	**6**	**(21)**	**453**	**290**	**722**	**875**	**881**	**1,079**

Our thanks to the hundreds of people who contributed to the completion of this report.



Alberta Health Services